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Let's Stop Dreaming

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For some time Canadian nurses have been considering the pros and cons of governmental support of nursing education through the establishment of independent schools of nursing as opposed to the present pattern of hospital supported schools. The necessity of providing for the education of other professional groups has long been recognized as a public responsibility. We are all familiar with teacher training in normal schools and faculties of education which is paid for from the public treasury. Faculties of medicine, law, pharmacy, social work, home economics, etc., provide tuition and laboratory experience at public expense plus fees paid by the students. Only in the nursing profession is it still considered essential that young women shall make full return for their instruction by the services they render on the wards.

This situation is not peculiar to Canada. Various survey reports in other countries have indicated the weaknesses from a professional standpoint of this apprentice-like approach to education. So far very little positive action has been taken. The thing that is most seriously wrong is that, so far as this important matter is concerned, we have no plan of action at all, but only a dream. And dreams, though very fine in their place, are unsubstantial things on which to build a program for independent schools of nursing in Canada.

Our colleagues in the United States have passed the dream stage and this year are supporting a bill, which it is hoped will receive federal endorsation, asking for financial aid to nursing education as one method of counteracting the nurse shortage. During the war we had a sizeable grant from our federal government which enabled schools of nursing to expand their teaching facilities and thus to graduate some 45 per cent more nurses. The American nurses received the same kind of federal backing. But both of these were permissive grants — not legislative — and terminated at the conclusion of the war.

According to Alice R. Clarke, writing in the March issue of *R.N.*, American nursing leaders believe that

if federal funds became available on a more permanent basis, they should be used (1) to promote collegiate schools of nursing; (2) to prepare administrators and educators; (3) to accelerate the practical nurse program (which in our country is largely financed by public funds at the present time); (4) to grant federal aid to the best hospital schools of nursing during the transition period.

One of the very essential steps in preparing for such a program as that outlined above would be to have some functioning machinery to determine which are the "best hospital schools of nursing." Our American colleagues are miles ahead of us here for they have had a workable program for the evaluation and accreditation of schools of nursing for twenty years. We have talked about it for a long time. One of our strongest committees drew up a blue-print for us as to how such a plan could be made to function. Nothing was done because our national association lacked the funds to initiate even the preliminary steps. So far, the only real evaluation of schools of nursing that has been undertaken in Canada was that sponsored by the Canadian Conference of Catholic Schools of Nursing. For a brief report of what they have done turn to page 290 in the April issue of our *Journal*.

What can the nurses of Canada do to bring our activities into line with present-day advances? There are some very important things. First, *every nurse should acquaint herself with all of the facts*. Who wants to be the weak link that reputedly snaps when tension is put on the chain? This may mean attending meetings! It certainly will mean doing some professional reading! Second, *verify your understanding of the factual information* by discussing every aspect of it in forums such as have been proposed. Third, use every opportunity to *pass on your new information* to the general public who are as anxious as we are to see that adequate nursing service is available for all. Fourth, *support your local, provincial, and national associations* in their quest for the solutions to current problems.

Let us stop dreaming and start doing!

Graduate Nurse Shortage

Recently, the Canadian Nurses' Association distributed a new edition of "Facts about Nursing in Canada." It contains interesting information which every nurse should have at her finger-tips for ready reference. Take for instance the data on the oft-quoted shortage of nurses. Based on replies to a questionnaire sent out to hospitals, including sanatoria and public health organizations, the data in the following table give an indication that the worst of the shortage may have been passed:

	Per cent Shortage		
Nursing Fields	*1946*	*1947*	*1948*
General hospitals	21%	24%	27%
T.B. sanatoria	38%	34%	29.5%
Mental hospitals	55%	44%	42%
Public health (incl. V.O.N., industry, etc.)	24%	13%	17.7%
Total graduate shortage, including in 1948 the special services and private duty; (these were not included in previous years)	27%	28%	22%
Number of hospitals returning questionnaires	471	392	542

However, percentages may be deceptive. We need to realize that Canada still needs over eight thousand more nurses to meet current demands adequately. As the vast expansion program envisaged in the federal health grants becomes effective, the total number of nurses required will be even greater.

Be pleasant until ten in the morning and the rest of the day will take care of itself.

Rh Factor Incompatibility

H. G. Oborne, M.D.

Average reading time — 9 min. 36 sec.

Everyone is familiar with the necessity for typing and cross-matching blood before giving a transfusion and it is also well known that, if the proper type of blood is not given, the donated blood may be destroyed by the blood of the patient receiving it, resulting in a "transfusion reaction." It has also been recognized for many years that, in spite of very careful typing and cross-matching, there were occasionally unexplained ill effects or "reactions" on the part of the patient receiving transfusion.

In 1940, two experts on blood-typing were conducting animal experiments. They injected blood from Rhesus monkeys into rabbits and found that the rabbits produced an "anti-substance" in their blood serum as a result of the injection. When the blood serum of the rabbits—containing the anti-substance—was in turn injected into human beings, it was found to result in a destruction of the red cells of most human beings into whom it was injected. There was "something" in those cells which caused them to be destroyed by the rabbit serum. This "something" was named the Rh factor in honor of the Rhesus monkeys used in the experiments. Further testing of humans revealed that 85 per cent of the white population have this factor—they are Rh+. The remaining 15 per cent lack it and are termed Rh− .

This information serves to explain why properly typed and matched blood sometimes causes transfusion reactions. It also partially explains the cause of a hitherto mysterious malady known by three names in the order of its severity: (1) anemia of the newborn; (2) icterus gravis neonatorum; (3) hydrops foetalis. These may be summed up under the general term of *erythroblastosis foetalis*. The classic signs and symptoms of this disease are: jaundice within forty-eight hours after birth, and the development of anemia, often at birth but more regularly by the third or fourth day, becoming most profound by the end of the seventh or eighth day if the disease is not of the fulminating type. Death, due to anemia and anoxia, however, may occur within the first forty-eight hours. Enlargement of the spleen and liver are quite frequently present. Edema, and even universal hydrops, may be noted in the most severely affected babies immediately after birth. There is usually to be found a large number of nucleated erythrocytes in the peripheral blood but this finding is not necessarily a criterion of the disease. In most cases the final confirmation of the diagnosis is an Rh— mother and Rh+ father, an Rh+ infant and anti-Rh agglutinins (antibodies) in the mother's serum.

The condition is believed to arise in the following fashion: The Rh+ father transmits the + Rh factor, which is inherited like brown eyes as a dominant characteristic. If the mother happens to be Rh− and if fetal red cells gain entrance to the mother's circulation through some defect in the placenta as yet not fully understood, these cells can cause the production of "antibodies" in the mother's Rh— blood.

The mother's blood then, because of the same placental defect, passes over to the fetal circulation bringing minute quantities of antibodies with it which tend to destroy the Rh+ cells of the child, resulting in hemolysis and consequent jaundice with anemia, etc. The condition tends to become more severe in succeeding pregnancies with greater degrees of jaundice and earlier, often intrauterine, death of the infant.

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There are some interesting observations concern Rh incompatibility:

1. If a patient is pregnant for the first time and is Rh− with an Rh+ husband, she has an almost 100 per cent chance of delivering a normal child unless she has previously received a transfusion with Rh+ blood. There are not sufficient antibodies produced to harm the child.

2. If an Rh− female is transfused with Rh+ blood, anti-Rh agglutinins are produced. If she subsequently becomes impregnated with an Rh+ child by an Rh+ husband, then pregnancy further stimulates the mother's antibody production and even the first child may suffer from severe erythroblastosis foetalis. This type of transfusion sensitization always results in the severest forms of the disease.

3. If an Rh+ wife has an Rh− husband there is practically no danger to the baby because the Rh+ mother cannot produce antibodies.

4. If both husband and wife are Rh− there is some danger to the child because the husband may not be wholly Rh− (i.e., heterozygous) and may possess some Rh+ elements in his blood, enough to produce an Rh+ child.

5. An Rh− female with an Rh+ husband who is heterozygous and who has previously produced an erythroblastotic Rh+ child may occasionally produce an Rh− child free from the disease.

6. The Rh factor has no influence in causing abortions since antibodies are not usually produced in sufficient quantity to harm the baby until late in pregnancy.

7. Once an Rh− female becomes sensitized to the Rh factor she remains so for life despite the fact that antibodies may not be demonstrable in the serum. Transfusion of Rh incompatible blood into an Rh sensitized individual may and all too frequently has resulted in a fatal hemolytic transfusion reaction.

8. One of both of the two types of antibodies may be elaborated by a sensitized individual: simple agglutinins and blocking antibodies. The latter when found in the serum have grave prognostic significance since there is evidence that this type of antibody may be responsible for the more severe forms of erythroblastosis foetalis. Practical methods have been devised for the detection and quantitative estimation of both of these antibodies in the sera of sensitized persons.

Management of Erythroblastosis Foetalis

In anemia of the newborn, the mildest form of the disease, recoveries occur usually with treatment or even without it. Most infants with icterus gravis survive if treated but may sustain cerebral damage of a permanent nature. In hydrops foetalis, the most severe form of the disease, the outcome is invariably fatal. It must be understood that these terms represent only a rough classification and that there is often considerable overlapping of signs and symptoms.

It is essential that the Rh of all pregnant women should be known by the fifth month. The husbands and all previously delivered children of the Rh− women should be Rh typed. In those with Rh+ husbands antibody tests should be started not later than the sixth month. It is our practice to repeat tests for antibodies every month unless we find a rising titre. In such cases the tests are repeated every second week.

An initially high titration or a rising one is presumptive evidence that the child will be born with eythroblastosis. If blocking antibodies appear the outlook is even more certain and indeed grave.

There is difference of opinion as to the advisability of induction of labor in the eighth month because of rising antibody titre. In our clinic we do not favor this procedure and tend to let patients go to nearer term in order to avoid the problems of prematurity complicated by erythroblastosis. The induction of premature labor when antibodies are present but not increasing is never warranted.

In the presence of rising antibodies it is our practice to do RBC, Hb and smear of the baby's blood on delivery and to transfuse at once (within two hours of birth) if anemia, etc., makes this necessary. Our transfusion procedure is the replacement method, using repeated alternation of blood removal with administration of equivalent amounts of Rh− type 0 blood through the umbilical vein. The cord is left long for this purpose.

It has been recommended, if the

mother has lost one or more children and is Rh−, that a Caesarian section be done at the eighth month in order to ensure a living child. We do not believe there is justification for this because if the baby is erythroblastotic there is the problem of both disease and prematurity to cope with.

There is at present no certain known method for the inhibition of antibody production in the mother prior to labor, although preliminary experimental work suggests this possibility in the near future.

It must not be inferred from the importance and frequency of articles on the Rh factor that it is a common problem in obstetrical practice. Approximately 14 per cent of adult white females are Rh negative. All of these will not marry and a proportion of those who do will mate with Rh negative husbands so that the total who give evidence of antibody production may be as low as 4 per cent. Most will have at least one child free from erythroblastosis and subsequent children may be saved by prompt treatment.

Erythroblastosis Foetalis

ISABEL MCKAY

Average reading time — 12 min. 48 sec.

BABY JOAN was the fourth child of Mr. and Mrs. Smith. The mother, aged 33, had been a stenographer prior to her marriage. The father has been with the R.C.N. from the outbreak of World War II. The family have lived in Victoria only two years. There is no record of hospital admissions here prior to this one and, consequently, no records of previous pregnancies or abortions which might indicate the discovery of the difference in the Rh factors of the husband and wife.

Baby Joan was delivered, an apparently normal female, weighing seven pounds, eight and one half ounces, at 3:44 p.m. on July 30, 1947. There was no evidence either of jaundice or edema at that time. Silver nitrate was instilled in her eyes as a precautionary measure against venereal disease. She was admitted to the nursery, howling lustily. A short time later she was sound asleep.

She was a beautiful baby, from an artist's concept. Her tiny features were perfectly formed. She was round and chubby and had dark, curly hair. Her eyes were bright and shiny, her lashes long and curling. Her skin was soft and smooth, but possibly paler than that of most newborn babies.

Fifteen hours later a marked jaundice appeared. Examination followed and a complete blood count was ordered; also a smear for erythroblastosis, a blood-typing including the Rh factor, and a cross-matching for transfusion. The laboratory results were:

R.B.C.	3,970,000
W.B.C.	40,000
Hemoglobin	85%
Polys. 53, Lymphs. 43, many Polychromatocytes	
Occasional nucleated red cells.	

When the formation of erythrocytes has been completed all nuclei have been extruded. The presence of nucleated red cells (erythroblasts) is of definite diagnostic importance. At this point the possibility of congenital syphilis must be ruled out. The leukocyte increase, added to the lowered hemoglobin and increasing jaundice, resulted in a definite diagnosis of erythroblastosis foetalis. To counteract the dangers

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present in this condition a strict régime was instituted immediately:

1. Only boiled water for feeding until a formula could be ordered. Infants with hemolytic disease are not permitted to nurse because anti-Rh antibodies have been detected in the colostrum and milk of mothers.

2. Synkamin 1 ampoule twice daily. Blood platelets decrease greatly in the first few days. Petechial hemorrhages and prolonged bleeding may occur. After the first week platelets generally return to normal and no further bleeding tendency exists.

3. Rh negative blood 100 cc. to be given by cut-down.

To understand this, it becomes necessary to understand the cause of erythroblastosis foetalis. It is a disease in which there is a disturbance in the production and destruction of red blood cells.

"Suppose an Rh negative woman becomes pregnant and that the fetus carrying the dominant genes from the father is Rh positive. Her antibody titre (standard of strength per volume) may be extremely low at the onset of pregnancy but, as the fetal cells escape into the mother's circulation during the last trimester of pregnancy and during labor, causing sensitization, so in this pregnancy the cells (fetal) pass into her bloodstream. These cells reawaken the antibody-producing mechanism, stimulated by previous Rh positive cells in the mother's circulation where they had been introduced previously by injection, transfusion, or pregnancy.

"Now the mother's serum is flooded with Rh positive antibodies. But her serum passes with ease through the placental barriers, and into the fetal circulation pour anti-Rh positive antibodies. Thus, the fetus, before or at delivery, has in its serum its own Rh positive red cells as well as the antibodies which will attack these red cells. Now the vicious process begins. The antibodies destroy the red cells, causing jaundice and anemia. To compensate for this the erythrocyte-forming organisms, normally present in the marrow, liver, and spleen in the newborn, begin producing immature red cells rapidly. The fetal circulation is flooded with immature red cells."[6]

With this explanation, the need for transfusing the babe with Rh negative blood becomes obvious. Rh positive blood would only increase the action of the antibodies, thereby increasing jaundice, anemia, and tissue destruction. Even if death does not result, icteric straining and degeneration of the nuclei of the brain may lead to permanent impairment of mentality. This treatment of blood transfusion is aimed at replacing the red cells until the present antibodies disappear. Thus the need for discovering the hemoglobin content before the giving of transfusions since the hemoglobin is in its first stages of development in the erythroblast, but the concentration increases as development advances.

Different degrees of destruction in this disease require varying amounts of blood by transfusion at varying intervals — that is, mild cases may not require more than 100 cc. of blood while those of a more severe nature may need 500 cc. or more given over a longer period of time.

The cut-down needle was left in place and irrigated every two hours with a normal saline solution. The transfusion was started at 12:30 p.m. and ran well. At 10:00 p.m. Baby Joan regurgitated a large amount of sterile water at feeding. Her cry was weak and she appeared listless.

The following day she was put on a formula of evaporated milk, oz. 4, boiled water, oz. 14, dextrimaltose No. 1, 1 tbsp.; divided into six feedings. Maonine .25 mgm. was given four times daily. She took this formula well and seemed more active until August 3, then the urine began to be more concentrated due to the presence of bile pigments. (Urobilinogen is excreted in increased amounts during the stages of active hemolysis.) On August 4, the jaundice on the face appeared to be more intense, but was not so marked on the lower extremities. Her hemoglo-

bin, which had been up to 106% after the initial transfusion, had, by this time, dropped to 92%. Slight vaginal bleeding was also noticed. The synkamin dosage was increased to four ampoules daily. Then she was given her second transfusion, this time 60 cc. of Rh negative blood. Following the transfusion Baby Joan seemed to brighten up. It was noted that these periods of interest were comparatively short. During most of her waking hours she was very lethargic. Frequently her limbs would appear to be quite limp.

The cut-down needle was removed from her ankle with resultant bleeding. Tiny sutures were inserted to close the gap and a penicillin cream dressing was applied.

She began to be dissatisfied with her formula; after feedings she was irritable. The formula was increased in proportion nd quantity. By August 7 she was a more satisfied babe.

On August 8 the sutures were removed from the ankle. A slight, purulent discharge was evidenced. Once again a penicillin cream dressing was applied.

The next day her hemoglobin had dropped to 85%. An attempt at a cut-down proved unsuccessful. A 19-gauge needle was inserted into the longitudinal sinus through the anterior fontanelle, and 40 cc. of Rh negative blood was given. Following this transfusion the baby's color was poor, her lips cyanosed; she regurgitated most of the next feeding. However, by evening, she had brightened up and took her feeding well. Now she was being given Infantol, drams one-half daily. The synkamin dosage was discontinued August 12, the danger of hemorrhage being past.

For the next few days her general condition seemed improved. Temporarily she appeared brighter. Saturated solution of iron and ammonium citrate, drops 1, were added to her feedings. Suddenly, as quickly as she had seemed brighter, she dropped into a state of lethargy; her mouth hung open, her eyes became dull, her general features took on a thickened appearance; there was little of natural movement in her arms and legs but, gradually, a twitching motion came over them. Then she would have periods of restlessness, and a weak, piercing cry would be heard. She did not take her feedings at all well; her hemoglobin dropped to 70%. Late in the afternoon of August 15, a cut-down was done and Baby Joan was given another 100 cc. of blood. The resultant change was very marked; she began crying lustily; at meal-time she did not waste a minute nor a drop of milk. She was now seventeen days old.

Thenceforward her general condition appeared to improve. The jaundice was becoming gradually less marked, her urine less concentrated, and her hemoglobin rose to 96%. Desynon, min. V., was given daily and ascorbic acid, .25 mg., twice daily. A laboratory report, on August 20, showed:

R.B.C.	4,890,000
W.B.C.	13,350
Hemoglobin	87%
Erythroblasts	Nil.

In a physical examination at this time the heart sounds were regular and normal; no cardiac enlargement was detected; the lungs and the pleurae were normal; in the abdomen, palpation suggested a palpable enlargement of the liver and the spleen. There were no other "abnormal" findings in the abdomen.

On August 30, Baby Joan, bright and happy, was discharged.

The prognosis: Apparently, it was very good. However, it becomes essential to consider several factors and to keep them in mind during the growth of a child of this type:

First is the question of blood. Will there ever be any danger of reaction in a blood transfusion, if a typing for the Rh factor were not done? (e.g., accident, etc.)

Second, what significance, in later years, will the finding of the enlarged liver and spleen have? Will this damage be permanent, thereby shortening the life expectancy? In less severe cases subsequent juvenile cirrhosis may occur.

Third, persistent jaundice is usually indicative of kernicterus. The twitching is another sign of this condition. Later in infancy, blindness, deafness, and spasticity have been discovered in about 6 per cent of patients with icterus gravis.

Fourth, he jaundice conceals a severe anemia. During her stay in hospital, Baby Joan was given iron and ammonium citrate drops; these were discontinued when she was discharged. Will she continue to improve without the aid of iron supplement? I have observed a little girl of eighteen months who is still very pale. Whether or not this can be attributed to the fight with the disease at birth or to the diseases she has had since is another consideration.

Special considerations in nursing care: 1 Regulation of diet: In a great percentage of cases these babies have been observed to have problems. Then, too, there is the consideration of dietary supplements of vitamins and minerals. Essential aminoacids are given to reduce liver damage as much as possible. Observation of the infant at feeding time is of the utmost importance.

2. Medications, as may be seen, must be given strictly and conscientiously in order to build up the child whose start in life has been so unfavorable.

3. Instruction of the mother is one of the major responsibilities of the nurse. The mother must understand thoroughly the necessity for having regular medical examinations made on the baby. Frequently, a severe anemia does not develop until the second or third month and, for a time, might pass unnoticed.

Usually, by the end of two or three months, the infant should have fully recovered.

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In the Good Old Days

(*The Canadian Nurse, June, 1909*)

"Private duty nurses should have two sets of everything, from underclothing and tooth-brushes to work baskets and writing materials, so that one set may be neatly packed and ready to fly with us when a call comes, the other just where we want it in leisure moments at home."

* * *

"Think what it would mean to the community if every trained nurse were a health missionary, teaching those who need the lesson the value of wholesome food, exercise, sunlight, fresh air, the danger of patent medicines, stimulants, quack doctors, etc."

* * *

"The wards (in Canadian hospitals) with their white-washed walls — mostly tinted — struck me as looking cold and comfortless and lacking in furniture. I missed the plants and flowers that one always sees in wards in England. The red blankets at the foot of the beds give a look of comfort to say nothing of their supposed efficacy in keeping off fleas. While it may be advisable from one point of view that the wards should be scantily furnished and the surroundings kept as aseptic as possible, a touch of color, not a variety of colors, is a relief from the monotony of the immaculate white."

* * *

"The present nursing staff of Winnipeg General Hospital numbers over 120, and few if any hospitals are of greater importance to the Dominion."

* * *

"This summer the Pacific Coast Tour (via C.P.R.) is especially attractive and rates are exceptionally low — only $74.10 Toronto to Seattle and return.

The average life expectancy in Canada and the U.S. is sixty-three years. In India, it is only twenty-seven years. It is estimated that a million people die annually from malaria — a preventable disease.

Feed a Fever

LAWRENCE RANTA, M.D., D.P.H.

Average reading time — 21 min. 6 sec.

IN 1945 a patient recovered from a major abdominal operation. This fact alone could hardly warrant the inclusion of the case among medical oddities. But that patient had been maintained and actually prepared for a trying operation, solely by intravenous feedings for a period of forty-six days!

A couple of decades ago, such an achievement would have been classified among idle dreams, among the medical impossibilities. It was too much to expect life to hang for long by a slender rubber tube and steel needle. Even ten years ago, we saw such patients die. And we knew why. They died because we knew too little about nutrition.

We knew a little more than did William Bulleyn — the grandfather of Ann, who lost her head over Henry the Eighth. In his writings, William advocated a succulent morsel for the treatment of nervous afflictions of children. He recommended: "A small young mouse, roasted!"

Two hundred years later, the knowledge of nutrition had advanced perhaps a step or two. On the advice of an eminent commission in 1739, the British Parliament passed a Bill providing for the payment of £5,000 to Joanna Stevens — such an amount had a purchasing power of nearly a quarter of a million of today's dollars. For this substantial reward, Joanna delivered to the British people her secret of some wonderful concoctions guaranteed, among other miracles, to dissolve kidney stones. The concoctions included various ingredients, but they consisted principally of ashed eggshells and snails.

Now, two hundred years after Joanna Stevens made her profitable deal, we have come to the threshold of an adequate understanding of human nutrition. I claim it to be no more than the threshold, for, though the road heretofore has been long, nevertheless it has been fairly straightforward; but the allusions arising from the growing knowledge of the interplay of nutritional elements threaten us with evidence that the road has led not to an open plain— rather to the entrance of a dark labyrinth. But while on the road we forded a Stream of Blood.

Based upon the concept that ill-health resulted from an accumulation of poisonous "humors" in the blood, it became customary to bleed the patient in the hope of drawing off the noxious products. The phlebotomist of the 18th century would have staked his reputation on the essence of this bit of ancient doggerel:

> By bleeding, to the marrow cometh heat,
> It maketh clean your brain, relieves your eye,
> It mends your appetite, restoreth sleep,
> Correcting humors that do waking keep.
> All inward parts and senses also clearing,
> It mends the voice, touch, smell and taste, and hearing.

For more than a millenium bleeding was a common practice, but during the 18th century it became a pernicious and persistent treatment.

In that period, the *Mercure de France* reported the particulars of illness suffered by a young married woman, aged twenty-four years. She was under the care of Monsieur Theveneau, Doctor of Medicine of St. Sauge, who bled her *three thousand, nine hundred and four times* in nine months. Even if we assume that an unscrupulous editor took the liberty of multiplying the actual figure by ten, or even a hundred — to make the item more newsworthy — it could not have represented the best treatment

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for any known type of disease.

It was about this time that a doctor confessed, in words more truthful than poetic:

> The grave my faults does hide,
> The world my cures does see;
> What youth and time provide
> Are oft ascribed to me.

The amazing feature of Dr. Theveneau's case was that the patient recovered. But all were not so fortunate. Sometimes disastrous results attended the bleeding operation — results too sudden and too final to be overlooked. Yet, even under these circumstances, an often unbelievable tolerance marked what has been called an intolerant age. For example — a young Polish princess, in 1773, lost her life when her surgeon used his lancet so clumsily that he slashed an artery instead of a vein. In her will, made on her deathbed, no ugly marks of criticism appeared. Fever, love, or Christian charity dictated the following clause:

> Convinced of the injury that my unfortunate accident will occasion to the unhappy surgeon who is the cause of my death, I bequeath to him a life annuity of 200 ducats, secured by my estate, and forgive his mistake from my heart. I wish this may indemnify him for the discredit which my sorrowful catastrophe will bring upon him.

It is apparent from this item that sudden disasters resulting from bleeding might bring "discredit" upon the erring surgeon, especially if the victim were royalty. However, few were the voices raised against the practice in that century. It is obvious that the "slow insult" was encouraged. Nevertheless, such misadventures, as the one which befell the (necessarily) beautiful princess, gradually but inevitably brought bleeding to disrepute although, even to this day, bleeding is practised on May Day among some remote peoples.

As bleeding for therapeutic purposes was discarded, its place was occupied for a while by a second evil-purging — which still has many adherents, if one may believe that modern advertising mirrors the demands of the day. Despite these remnants of a dead age, the tortuous treatments suffered in the name of Hygeia have given way to scientific feeding. It was not until the present century that the life-saving practice of intravenous feeding became feasible. But, like most procedures in medicine, it has its roots buried deep in the past.

During the past four hundred years, little was heard of transfusion techniques. But some of the more courageous conducted experiments. At the turn of the present century, physiological saline, later glucose-in-saline, were applied intravenously to the treatment of the dangerously ill. As the facts of blood typing were learned, blood transfusion became a standard procedure. Of these modes of intravenous therapy, only blood transfusion could be considered to approach temporary adequacy of nutrition, but its usefulness was definitely limited. It could not be used continuously, it provided blood cells whether they were needed or not, it was relatively unstable, it was limited in supply, and it involved an extraordinary expense.

During the war, investigations indicated the advantages of certain substitutes for blood in transfusions. Protein hydrolysates, the products of chemically split proteins, usually casein, seemed to be the obvious answer, provided that they were reinforced with vitamins and essential minerals. Their success was considerable. But, even at the present stage of development, they are not the complete answer to human nutritional problems during recovery from accident or disease. One important question remains to be answered, namely: How may essential fats be provided in a form not dangerous to the patient by the development of fatal embolism, of fatty degeneration of the liver and other organs, and of troublesome sclerosis of the recipient vein? The solution to this problem is not far off. Yet, despite its imperfections, reinforced protein hydrolysates do reflect the growing knowledge of

human nutrition, particularly of the role of amino acids.

There is no class of compound more intimately associated with the central processes of life than the amino acids. We are well aware that they go into the structure of all tissues, constituting the principal ingredient of cellular protoplasm. But they also go into the formation of the master hormones and enzymes which are the controllers of the body mechanisms. Moreover, they are the compounds from which our defensive antibodies are developed.

Even the genes, through which our ancestors keep control over us so effectively, are most certainly formed from amino acids. The recent discovery that certain chemicals — the nitrogen and sulphur mustards — are able to alter the genetic composition, thus giving an artificial heredity to a cell, is a step into a new realm of genetics thus far explored only by Hollywood. The action of chemicals on genes and chromosomes opens up new and intriguing prospects, both in understanding evolution and in producing selective changes of hereditary characteristics.

Although there is no need to discuss amino acids in any chemical sense, I would like to recall to your minds that amino acids in human nutrition have not presented the simple solution to nutritional theories that might have been conceived at one time. For, in the study of amino acids as in many other scientific fields, the road that seemed so straight and smooth was found, on greater familiarity, to be unexpectedly difficult. The Coach of Knowledge has travelled it with many a creak and groan.

The detoxifying action of glutamine, glycine, and methionine has broadened our views on the functions of amino acids; the possible production of thyroxine from tyrosine has added yet another link to bind protein and carbohydrate metabolism together. Moreover, the mysteries of allergic reactions seem closely bound to the metabolism of histidine. And what of the problem of the degenerative diseases like forms of heart disease, high blood pressure, cancer, and even old age itself? Here, again, the amino acids are apparently involved. Whether they are innocent bystanders, victims, or culprits, cannot yet be determined. Only the future will bring us the data on which to base a judgment. Nevertheless, we can be sure that the reactions of amino acids in the test-tube and in the living tissues will contribute much to the solution of these major medical problems. The Brave New World need not despair that there is a dearth of worlds to conquer.

Protein and Resistance to Infection

I mentioned that amino acids are directly associated with the mechanisms providing us with resistance to infectious diseases. An hour spent with Creighton's monumental "Epidemics of Britain," published in the latter part of the last century, will reveal how many times the author called attention to the occurrence of a famine prior to the onset of an epidemic. These observations, though uncontrolled in a scientific sense, are indicative of a famine-epidemic relationship.

In recent decades, in some unfortunate territories of the world, unhappy peoples have confirmed these observations. In Europe and Asia the stage is still set for a devastation by disease such as modern times have never seen. Epidemic hazards have often carried sparks into the powder-keg of malnutrition.

It was not until very recently that a scientific reason has been advanced for this side-effect of famine. It still remains largely in the realm of conjecture, but it forms a pattern compatible with our information. Let me first introduce it in barest terms. Resistance to infection is determined largely by the presence of antibodies in the blood stream. Antibodies are specific serum globulins. Specific serum globulins are altered normal globulins. Normal serum globulins are constructed from amino acids by special cells, perhaps

the reticulo-endothelial cells of the body.

The reticulo-endothelial cell system is an aggregation of fixed cells occurring in the bonemarrow, liver, spleen, and elsewhere in the body. Whatever else they may be required to do in the economy of the body, one of their functions is at least the absorption of amino acids and perhaps of even larger components of proteinaceous material. Out of this material the cells are thought to construct a substance found in normal blood serum — a protein fraction known as serum globulin. The production of serum globulin is an essential and persistent function. A constant supply of serum globulin is manufactured and released to form part of the protein substance in the blood plasma.

Another function of the reticulo-endothelial cells is the *adsorption* of protein particles from the blood stream. These cells are closely related to the white blood cells and serve as a sort of fixed scavenger system. In particular, the reticulo-endothelial cells pick up the foreign proteins which usually find their way into the body during an infection — these foreign proteins are actually protein components or the enzymes of bacteria and viruses.

Thus, we have a picture of the globulin-producing cells with foreign bacterial proteins adsorbed on to their surfaces. When a molecule of globulin is formed by the cell, it may occur close to the adsorbed particle of foreign protein. When this happens the globulin molecule comes under the influence of the foreign protein. It is, as it were, stamped with the picture of the foreign protein molecule. Now, instead of being the ordinary variety of serum globulin molecule, it is an antibody. It has a specific affinity, a neutralizing affinity for foreign protein molecules of the same type as that which influenced it at its birth. While the antigen, the foreign protein molecule, remains on the surface of the reticulo-endothelial cell, a certain proportion of globulin molecules produced by the cell will be "born" with a specific protective capacity against that particular type of foreign protein molecule.

As time goes on, the reticulo-endothelial cell becomes old. It reaches the end of its life. The cell is destroyed and a new one takes its place. When the cell dies, the adsorbed foreign protein molecule may also be destroyed, and there is that much less antigen to influence the formation of antibody. Should no more foreign protein molecules be introduced to compensate for the steady loss, the person gradually loses his immunity. Unless the antigen is preserved by fixation to another cell, the person again becomes susceptible to the bacteria that he was formerly able to resist.

Under certain conditions the loss of resistance may be speeded up. This occurs under conditions of protein starvation, when the reticulo-endothelial cells are not supplied with sufficient amino acids.

The production of globulin is a vital process. Although it may perhaps be slowed down appreciably, the production of globulin continues under all circumstances, even at the expense of other tissues.

When protein reserves are low, the reticulo-endothelial cells begin to draw upon the globulin molecules already formed. As they are brought to the surface of the cell, the foreign protein may unite with the globulin; and during the resulting surface-digestion of the globulin, the foreign protein may also be reduced to amino acids, and be consumed by the cell. Thus, the reticulo-endothelial cell clears itself of antigen — of foreign protein molecules. Henceforth, the serum globulins produced by the cell can no longer be converted into specific immune globulins — into antibodies. The initiator of specific defence is destroyed when the antigen is lost from the surface of the cell. Rapidly the individual's immunity disappears. Even after food proteins are again adequate, the individual may no longer be capable of protecting himself against bacteria, formerly

resisted specifically and efficiently. Consequently, after a period of famine, after a period of low protein intake, a whole nation, a whole race, may have its general level of immunity reduced to a point where little resistance will be retained against an invador formerly repulsed with ease.

Before proceeding, I should confess that the picture that I have presented has been painted in the bold colors of theory. Many of the details of antibody production have not been worked out. These details are to be filled in largely through investigation on the animal body. The technical problems to be overcome in some necessary experiments are a long way from being solved. Interpretation of the results of other experiments presents great difficulties. The animal body, with its billions of cells undergoing millions of chemical reactions, provides our understanding with no reasonably predictable way to success. Animal reactions are always hard to predict or interpret.

PROTEIN AND BACTERIAL TOXINS

The interpretation of some of the recent findings in the realm of bacterial proteins has re-emphasized some of the previously suspected problems. During the war certain bacterial toxins were isolated in crystalline form. One of these was Botulinum A Toxin. As you know, this is one of the toxins responsible for the rare, but deadly, food poisoning known as botulism. It is so potent that a minute quantity is sufficient to paralyze and eventually kill a human but, for all that, it is composed of fourteen different amino acids assorted in a large protein molecule. This toxin is an antigen, capable of adsorbing on reticulo-endothelial cells and influencing the formation of Botulinum A Antitoxin.

Botulism is produced when the toxin is taken by mouth but, in order to produce poisonous effects, it must withstand the hazards of a journey through ferment-ridden intestinal canal, survive its penetration through the mucous membrane of the intestine, and ride the blood-stream to reach the nerve cells. We must still learn why the toxin is not broken down into its component, innocuous amino acids. Why does it not nourish us in the same manner as the proteins of a beef steak?

Moreover, how does this particular combination of amino acids give it the properties of such a potent poison? It was suggested that the possession of unnatural forms of amino acids may be responsible. Some of these combinations are not well tolerated by the body. For example, gramicidin, one of the antibiotics, is a combination of amino acids, 45 per cent of which are in this "unnatural" form. This antibiotic is not well tolerated when inoculated into the tissues, but even with this large percentage of unnatural amino acids, it is not nearly so poisonous as botulinum toxin. In other words, how a protein acts as a poison poses a question that will not be easily answered. And every new answer will pose new problems, many of which will have direct association with the intricate mysteries of nutrition.

Speculating upon the mechanisms of antibodies and antigens is fascinating. On the one hand, we meet a protein, beneficially benign; and, on the other, a protein amazingly malignant. Every one of us is concerned with the course of future developments in this respect of immunology. Consequently, we may well focus our attention upon the work of those who are laboriously chipping and shaping some recognizable form from the hard granite of the secrets underlying the production of antibodies. They have already demonstrated that an adequate protein intake is necessary in order to safeguard the continuous production of protective antibodies. No other argument is needed to remind one of the necessity for a careful assessment of the nutrition of a patient who is attempting to battle an infection. No other argument is needed to remind one of the necessity for a careful maintenance of the normal protein intake of everyone. Yet how frequently do we leave the sick, espe-

cially, to fall back on inadequate reserves? Need more be said than this: The importance of an adequate intake of amino acids in both health and disease has been proven beyond a shadow of a doubt, and there are definite signs that the future will strengthen rather than diminish the value of these food elements. Let us not forget the dual role of the blood: not only does it nourish the tissues, it also protects us from attacks by our minute, worldly enemies.

When the past is allowed to reflect its light upon the open road of the future, another implication is encountered. Thrown into clear relief are the accomplishments of the present day. There is no denying that they are great. But they are only signposts along the way. And who can say but that some of them may stand in the same relationship to future knowledge as Bulleyn's roasted mouse and Stevens' ashed egg-shells and snails stand in relationship to the knowledge of the present day?

Information, Please!

HAVE you sometimes cynically wondered what happens to those questionnaires which always seem to arrive at the most inopportune and busiest time? Perhaps you decided that whether they were ignored or answered it amounted to much the same — they ended up in the limbo of forgotten things. Ah! That is where you are wrong! They have been in frenzied use and, far from being forgotten, they are referred to with rhythmic regularity.

For the two years in question, of which we report — 1946 and 1947 — questionnaires have gone out to schools of nursing in September for specific data on student nurses. The information sought was the "class wastage," annual withdrawal rate plus reasons for withdrawal, and student enrolment. Questionnaires were also sent to all hospitals for information on graduate nurses and auxiliary nursing personnel. Out of 170 schools that were sent questionnaires, 154 schools replied. These replies were summarized and are kept for your information in National Office.

The aim of the Canadian Nurses' Association in seeking such information is mainly fact-finding, namely:

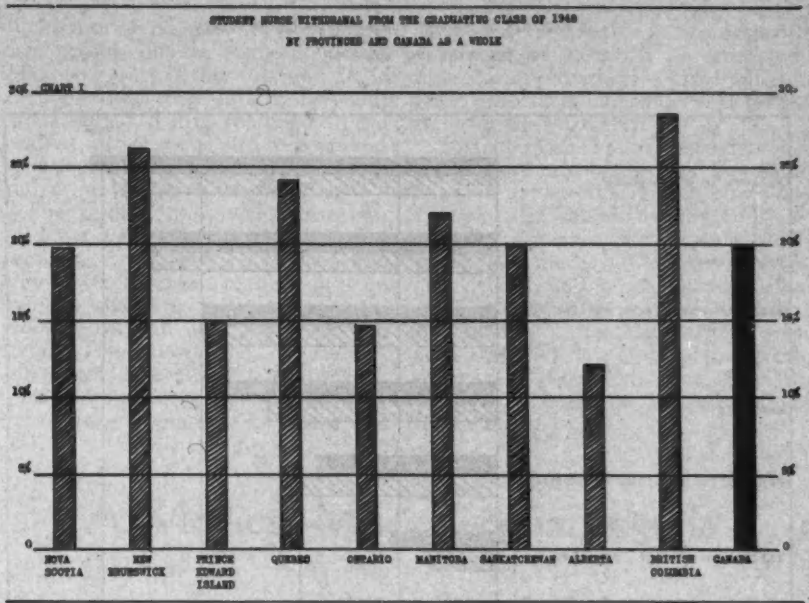
1. To have figures available: (a) For official governmental departments; (b) for non-official organizations; (c) for requests from other countries; (d) for questions coming in from nurses and nursing organizations across Canada.

2. To be able, eventually, to compare these figures over a period of years, so that more accurate estimates may be made of: (a) Number of nurses expected to graduate in the next few years; (b) the trend of graduate nurse and auxiliary nursing personnel shortage in the various fields of nursing; (c) the number of active graduate nurses and nursing assistants or aides available at a given time; (d) needs in nursing service to accommodate expanding community services, in a hospital and health program.

3. To assist each school of nursing to analyze their own school and compare their findings with schools of nursing in Canada as a whole.

To understand what we mean by this third aim, may we give an example paralleling a nursing problem with a medical problem — that of reducing a high mortality rate by applying intelligent research to discover cause and methods of prevention, and quote from "League Letter" edited by the National League of Nursing Education:

Schools of nursing might use the same method for studying the problem of student withdrawals and reducing the student with-



drawal rate. A committee of the faculty might study the entire record of every student who withdraws from the school . . . find out what reasons lie behind the phrase "dislike for nursing" . . . discover the early symptoms of the ultimate "failure" . . . investigate the steps taken when these symptoms were noted . . . find out why the measures were not successful . . . discuss other ways in which the problem might have been approached.

If you will refer to Chart I, you will find the Withdrawal Rate of Students from Schools of Nursing — i.e., "class wastage." This rate is based on the number of students who have withdrawn from the classes graduating in 1948, compared to the same classes who entered the school in 1945. The rate for the whole of Canada is 20 per cent. If the number who have had their graduation postponed (but still expect to graduate the next year) are included, the rate then becomes 22.2 per cent. Withdrawals from individual provinces range 12.3-28.7 per cent, and there is as wide a range among schools of nursing within any one province. Is this significant? Just what does it mean — that a school with low wastage is "good" and one with high wastage is "poor"? Let us consider two schools. "A" makes no attempt at wise selection of applicants and eliminates only under compulsion. "B" uses discrimination in selecting applicants, which necessitates fewer eliminations. Both then have a low wastage of students — or do they? Will School "A", though showing low wastage of students for the first six months of a year, show up higher at the end of the second and third years? Will poor selection mean higher withdrawal due to "Health Reasons" and "Dislike for Nursing"? Certainly it pleases us to see a low withdrawal rate but, in making any comparisons, between schools, between provinces, certain known factors should be equal.

In comparing spring and fall classes, the rate on the whole seems to be the same. Any difference is negligible, considering the few statistics available for comparison. It is interesting to note that 75 per cent of the student withdrawals occur in the first-year group, 20 per cent withdraw during the second year, and 5 per cent during the third year. These figures are based on the annual withdrawal rate.

AN ANALYSIS OF STUDENT NURSE WITHDRAWAL IN CANADA

FOR THE YEARS 1946 AND 1947

CHART II

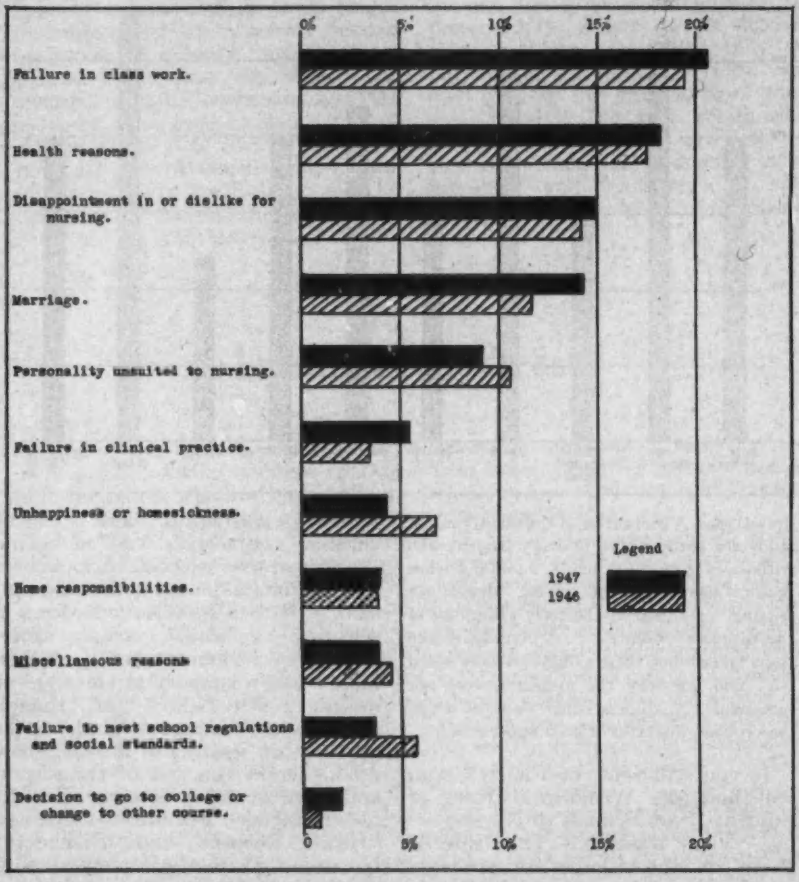


Chart II, Reasons for Student Withdrawal, is a comparison for two years — 1946 and 1947. Two years, of course, is too limited a period on which to base any statements other than what seems to be the trend. We find that during both years the four reasons most frequently reported for withdrawal from schools are the same, and take the same place in order of frequency. Eliminating "Marriage" as being something we cannot do much about if the student wishes to leave, we are left with three reasons which might very well be classified as: Educational, Physical, and Psychological. Would we lose fewer students from training if more careful screening were done on application to the school? Or does the fault lie more in the conditions under which the student must live, work, and study; hours on duty; arrangement of the educational program — i.e., grouping of subjects, number of hours spent on each subject, and whether given as a concentrated program or spread over a number of weeks; health program — the frequency and extent

of the routine physical check-ups and care during illness; counselling and guidance — whether or not it is available other than in a professional capacity and, if it is, the value to the student nurse; social and recreational facilities, planned by the students, and/or planned for the students.

The returns of questionnaires on graduate nurses and auxiliary nursing personnel were poor — 60 per cent only of the hospitals replied, and the findings, compared with the two previous years, can only point out the trend. This shows the increase of active graduate nurses and auxiliary nursing personnel. Shortage of graduate nurses seems to be about the same but, if anything, has slightly decreased, as shown by an estimated figure of approximately five hundred fewer shortages for the year 1948 than for the year 1946.

Statistics, such as have been quoted, with information based on fact, are of inestimable value to the National Office of the Canadian Nurses' Association for release to the public, and to supply those individuals, nurses and others, and organizations especially interested in such data, with the specific information they require. For such statistics do point up the trend of a given situation, that may be used as a basis for diagnosis and future action.

A Medical Missionary in Nigeria

A. M. (NANCY) SUFFILL

Average reading time — 4 min. 48 sec.

WHILE IN THE dispensary the other day I overheard one pagan talking to another and saying, "You can't go in there yet. We have prayer first and hear about God." It touched me by its simplicity because we have come here primarily with the good news of the gospel and try to further reach our primitive people by our medical work.

We are seven hundred miles in from the coast and on a plateau four thousand feet above sea level. Our local people are farmers and until recent years were quite unclothed except for a girdle of leaves. Many are beginning to wear clothes and these bring their problems. So often the blanket or garment is worn till the lice become too bothersome. Or the garment is washed and reworn still damp or even soaking wet. So we get many pneumonia cases and at present are having a real fight against "relapsing fever" caused by ticks and lice.

There are some other hospitals within a radius of seventeen miles but we still get fifty to sixty patients a day. This means a real responsibility in diagnosing as there is no doctor here.

Gavaging 2-week-old Connie

Miss Suffill graduated with the class of 1934 from Vancouver General Hospital.

I have had to treat some snake bites but, surprisingly, comparatively few. Treatment consists of incising the site of the bite and rubbing in potassium permanganate crystals. Then I give calcium lactate for several days to prevent bleeding which often occurs on the fourth or fifth day, causing death. Recently a lad came to me on the third day after being bitten by a puff-adder on the forefinger. His hand, fingers, and arm were horribly swollen and he had pain radiating down his left side to his leg. I gave him potassium permanganate soaks twice a day and a tight bandage. He cleared up miraculously. I had no need to incise him as his hand had begun to slough.

When a child was brought in immediately after being bitten, I was surely gratified for my nice sharp scalpel.

Three months ago, six men were brought in, or rather walked in, covered in blood, having been attacked and clawed by a large leopard about a mile from here. It took me four hours to clean the wounds, apply sulfathiazole powder and tight elasto bandages. Two of the six died, one, an old man with very severe head wounds, who also ran off to the witch doctor after all my trouble. The other had a fractured arm as well as a clawed posterior and possible internal injuries received when he fell off a bluff trying to get away from the leopard.

Recently, I was called to the dispensary at 10:00 p.m., to find the patient, a simple lad of seventeen years, lying in a metal wheelbarrow perfectly conscious His head hung over one end and his torn broken foot was dangling over the other end. In this position he had been wheeled over a rough road for a mile after being rescued from a twenty-foot well into which he had fallen. The tibia was out of its socket at the ankle, protruding about four inches and covered with sand and grit. The flesh was torn, leaving the foot hanging over about a 120° angle to the leg. My aunt (I am stationed with an aunt and uncle who have been here over thirty years now) came and gave a chloroform anesthetic. I washed the wound as quickly as possible and then with God's help got that bone back into place and put in about twelve linen sutures. We then applied a splint and more of those elastoplast bandages, which are a real boon, and put him to bed. Next day I called the doctor from our mission hospital seventeen miles away. He took him to hospital to give him anti-tetanus serum and also to apply a cast. This was a thrilling case for me as I love surgery. But I was surely "dripping," getting that bone into place, on a hot evening by the light of a Coleman lantern.

And now a little about our orphan work. My aunt really started this work about twenty years ago. She felt appalled at the fact of so many babes being "buried alive" with their dead mothers, or being killed by pouring boiling water and potash down their throats. Our people are terribly afraid of "Spirits," and when a Birom woman dies, they wish to dispose of her baby, too, as no other pagan woman would dare to care for the child. She would be frightened of the spirit of the dead mother. My aunt began to rescue these babes and bring them up on cow's milk. It has been an uphill job, but today it is gratifying to see so many lovely children in their Christian foster homes. One of these rescued children got married and had a lovely babe at Christmastime. I marvel when I look at her and realize that she survived the "boiling water and potash" treatment and has no injury to her throat.

Last year, in May, I was alone on the station as my folks were away on local leave. I had a Vancouver girl visiting me from her mission station about two hundred and seventy miles away. It was just getting dusk about 6:30 p.m., when two Africans arrived at my back door, one carrying a wooden box on his head. They lifted it down and took off the lid and there lay a wee tiny babe, naked and hungry. She was ten days old and her mother had died. These Christians had brought her in a

covered box about twenty-five miles. My friend Barbara said she would wash her as I had a breast fomentation to do at the dispensary. When I came back, Barbara had her looking more respectable as far as cleanliness was concerned. I weighed her and she was several ounces less than two pounds. She couldn't cry. I emptied out my laundry from a big basket, rolled her in a flannelette sheet, and put her in the basket on a hot water bottle. She lay in that basket for three months. By then she weighed six pounds. For her first three months she did not have another bath. I oiled her daily with warm peanut oil and kept her tightly rolled, arms too, in the flannelette. For the first week I gavaged her q.3.h. day and night with 1/3 milk, 2/3 water, and a pinch of sugar. Then after a week she was quite ready to suck. I gave her a bottle and she surely knew what to do. After she was three months old, I had to go and study my second African language and so a woman in the nearby tin mines took her for three months as my aunt had five other orphans. Wee Connie, (for so I called her), did very well and in February this year she went back to the Christian folk who had rescued her. They are absolutely thrilled with her and cannot believe how lovely and fat she has grown from so tiny a mite. I will never forget the expressions they used when they again saw her. They kept saying, "A thing of wonder!" Most of the Africans thought we shouldn't attempt to save such a tiny mite. She was sixteen pounds when she went away in February and had cut two teeth. Here are some pictures of Connie. She was a real thrill to me as I have never cared for such a tiny babe before.

At 10 months, Connie had two teeth

I trust you may all enjoy this glimpse of our work here on a bush-station in Africa.

Ontario

The following are recent staff changes in the Ontario Public Health Nursing Service:

Appointments: *Mary Jo McKenna* (B. Sc.N., University of Western Ontario), Lambton health unit.

Resignations: *Clare (Connolly) McGahey* (Ottawa General Hospital and University of Toronto certificate course) from United Counties health unit; *Louise McBurney* (Brandon Gen. Hosp.; University of Manitoba public health nursing course; B.N., McGill University) from Oxford County and Ingersoll health unit; *Marie Ford* (Montreal Gen. Hosp. and McGill U. p.h.n. course) from Kirkland-Larder Lake health unit; *Mary Cripps* (University of Iowa School of Nursing and U. of T. cert. course) from Peel County health unit.

M.L.I.C. Nursing Service

Gertrude Gouin (Notre Dame Hospital, Montreal, and University of Montreal public health course) has resigned from the Metropolitan Life Insurance Company. Miss Gouin was in charge of the nursing service at St. Hyacinthe, Que.

It is estimated that there are half a million completely blind persons in China, with perhaps fifteen million persons who are almost blind. The great majority of these eye conditions result from preventable disease.

Private Duty Nursing

Making Your Choice

MURIEL A. WARD

Average reading time — 3 min. 12 sec.

AMONG THE MANY FIELDS of our profession perhaps the one that we hear the least about in the student classroom is private duty nursing. Yet, to many young graduates, this type of nursing seems to be one of the most enticing. Still, proportionately few of these nurses join the ranks of the private duty nurses. Perhaps the lack of enthusiasm is due to the ignorance of those who would contemplate such work. If so, tarry a few moments while we briefly scan the salient features of this field of nursing.

During our three years of training much knowledge and information and many skills were taught us. Here is an opportunity to demonstrate that learning and really practise the art of nursing the sick. Private duty offers one of the best opportunities to employ all of our ability in bedside nursing. There is the time in which to accomplish all the little niceties which too often you have had to pass over hurriedly because of more pressing assignments. Here, too, there is time to follow the case closely and study more about the illness, its treatment, and prognosis. Spread before you are the textbook authorities with your patient to illustrate the clinical symptoms.

The private duty nurse of today is called to render aid and care, especially to the very ill patient. The average surgical case may require a nurse for from ten days to three weeks due to the advances made in post-operative treatment. With this thought in mind it is easy to visualize the variety and experience which can be obtained in this branch of nursing.

Miss Ward is a private duty nurse in Hamilton, Ont.

Not only does private duty offer variety in cases—people and their ailments—but also you may find yourself located in any one of a dozen hospitals and occasionally in a home perhaps in the city or even in the country.

Consider what may be accomplished in eight hours spent with one patient. Marvellous teaching opportunities are laid before you, not only with the patient but with all the members of her family.

The majority of your cases will be cared for in a hospital. Some of the factors will be different from what they were when you were a student. You will find the attitude of the staff nurses very altered in the first place. The private duty nurse is on her own —she is largely responsible for the total care of her patient. No one runs along behind her to think of the many details in a day's work which she may be a bit careless about. A sound understanding of your art, common sense, and the love of humanity will help build that self-reliance which you feel you require. Know the requirements of a 100 per cent job, and set your goal high. Then have the courage to discipline your will and reach that goal. It is up to each private duty nurse to keep her own personal standards at the highest level.

Yet, with all the practical knowledge she may possess on private duty, the nurse must "see herself." You are a graduate, a registered nurse. Therefore the public has confidence in your ability to nurse but does your attitude inspire co-operation from everyone with whom you come in contact?

Have pride in yourself and in the nursing care you administer.

Public Health Nursing

Ten Years in a Rural District

LILIAS M. TOWARD

Average reading time — 12 min. 6 sec.

TO PEOPLE living in cities the word "nurse" conjures up a trim figure in stiffly starched uniform, gliding down the corridors of a hospital. To the people of Victoria County, on the Island of Cape Breton, situated on the extreme easterly edge of Canada, the word "nurse" presents a very different picture. They see her not dressed in a spotless uniform but wearing possibly a plaid skirt and lumberman's jacket, hastening to the next call. She drives her own car in summer; in winter she may be seen muffled in a fur robe, sometimes snatching a few minutes sleep, in the bottom of a box sleigh. In the spring of the year, when the roads are well-nigh impassable, you may find her seeking transportation on any kind of vehicle. She may leave her own car stuck in the mud to the axles and continue her journey by truck or on a bulldozer.

This nurse, the first permanent public health nurse in Victoria County, was sent to develop a generalized public health nursing program, including maternity services. She has for her district a rural area fifty miles in radius with the village of Baddeck as its centre. Serving this scattered community of five thousand people is one doctor, who is the medical health officer, and this nurse. While a hospital is now nearing completion, it is still necessary to transport patients over fifty miles for institutional care. It is not surprising, therefore, that practically all expectant mothers are confined in their own homes.

Often a fisherman returning from his nets, or some other early traveller, sees the tired face of the nurse coming home in the grey dawn after spending most of the night in a lonely farmhouse back of the mountains, bringing new life into the world. Perhaps she has been assisting the doctor but it is quite possible that she was there alone. It often happens that the doctor is called elsewhere and it falls to the nurse to deliver the baby by herself.

This early morning fisherman is pleased to be hailed pleasantly, possibly by some inquiry regarding an ailing member of his family. Regardless of the hour, the well-being of the people of this district is of great personal concern to the nurse and, like an anxious mother, the sick child, or other patient, is always in her thoughts. Laying aside his rod, the fisherman approaches her car and answers her kindly questions. Being of an inquiring turn of mind himself, he asks the nurse a question or two concerning her work — and why under the sun she chooses to work all hours! As the nurse begins talking of her work, the tired, strained look leaves her face and is replaced by one of joy, for only a person who loves her work can give of herself as this one does. Perhaps she will proudly confide that this is her "595th baby." "Not every old maid can boast of such a family, and all in ten years," she will exclaim with glee. Forgetting the exhausting night barely past, she finds herself talking of the early beginnings of the public health work in her district.

"I suppose you'll soon be moving

Miss Toward has based her story on the experiences of Phyllis Lyttle, R.N., a public health nurse with the Cape Breton Island Health Unit in Nova Scotia.

into that fine new provincial building they are erecting?" inquired the man.

"Yes, I am to have a suite of offices there — quite a change from my own bedroom, and from the sheriff's office in the County Court House, isn't it?" said the nurse with a chuckle. Then she went on confidentially: "Do you know, I'll be sorry to move, for I feel that the room in the Court House belongs to all of us, not because we are rate-payers but because we worked for it. Do you remember what it looked like in the beginning with its dingy walls and its one table and four chairs?"

"Yes, I remember," said the man with a twinkle in his eye, "and I remember the dance we arranged to raise funds to have it put in order; there was a fiddler's contest and a pie sale. I guess we did pretty well that night."

"We certainly did," admitted the nurse. "We raised ninety-five dollars at that dance, and the following morning I bought paint and Joe MacDonald worked until two in the morning painting the place. You wouldn't have known it!"

"I have forgotten how you got the furniture," said her companion.

"That's not surprising, for it came from many sources — the bank manager loaned us a typing table, the garageman sent over an office chair, and my desk once occupied a place in the Legislative Assembly — that was the local member's contribution. The table with the tape on it, that I use for measuring babies, was made at the yacht building yard. The people of Tarbot took up a collection and bought the couch. It was that way with everything. Whenever the people heard that I needed something, they found a way of getting it. At first I had to go across the street to telephone, but when the young girls in the community heard about it they sponsored a dance and raised money to install a telephone. It's not much wonder I feel attached to that office and that the people around here feel they have a share in it."

"I suppose you will try to get some sleep this morning?" he asked.

"Oh no, there won't be time for that," laughed the nurse. "I have a school clinic in Iona this morning — how do you think I can get around the sixty-odd schools in my district if I sleep my life away?"

"What do you do at the schools?" queried the man.

"We check eyes, teeth, throat and skin of all the children; give a patch test for tuberculosis to all the children over twelve years and repeat it yearly if the reaction is negative; arrange for home nursing and first aid classes for both children and adults; and every year I try to give a series of eight or ten lectures in as many as possible of the districts.

"We have to make sure that all the children are vaccinated and immunized. Sometimes we conduct a special test in one or other of the schools. In 1940 we immunized all the children in the Little Narrows school against whooping cough and not a single child in that school got it although it was prevalent in the neighboring section. We carried out a similar experiment with toxoid for diphtheria with equal success and now we are doing the same thing with a new toxoid.

"When visiting the schools, I always take the opportunity of giving a talk on nutrition, urging both teacher and children to realize the importance of balanced lunches. By taking my own lunch and eating it on the school premises I have a chance of illustrating my talk and, incidentally, finding out the type of lunch the children are getting. One objective I always seem to have in the front of my mind is to have hot lunches served in the schools, with proper washing and eating facilities.

"It is one of my duties to inspect the school premises and make sure that they are kept in proper condition. Usually the trustees are anxious to do all they can in this respect, but in one particular school it took them two years to build a privy. When I bitterly complained of their negligence, they shrugged their shoulders and retorted, 'Two years isn't long

building a privy, when we've been fifty years without one.'

"As a result of my school clinics, I visit the homes of those children suffering from serious physical defects to try to get something done for them. If the parents are unable to do anything, then it is up to me to find someone willing to help. Often the county will assume responsibility, sometimes the Rotary Club will, or the Junior Red Cross or the local board of health. Considerable help is received from individuals in the way of clothing, mattresses, and bed-clothes for some needy cases, as well as offers of transportation when required."

"You have a special tuberculosis program, haven't you?" inquired the man, whose interest had been completely aroused in a service which, for the past ten years, he had either ignored or taken for granted.

"Whenever tuberculosis cases are found to be active and open, we visit them regularly and try to arrange for their admission to a sanatorium as soon as possible. With all contacts we carry out our routine of follow-up. At first the great difficulty was to locate the cases that were active for, when we started to work here, the people regarded tuberculosis as a disgrace to the family, so that even when they suspected it they avoided seeking medical care. We had our first X-ray clinic in 1939 in the doctor's waiting room; only six persons came and they were all from the same family. Now it is usual for over two hundred to attend our clinics held in the spring and fall. All tuberculosis contacts are checked regularly and we arrange for individuals to be x-rayed without cost. As I have already mentioned, school children over twelve years of age are patch-tested and, if found positive, x-rayed. When necessary I give instruction in bedside nursing so that someone in the home can carry it out."

"That sounds like a lot of work to me," states her fisherman friend. "How do you manage to find time, with all that program, to bring so many babies into the world? I heard that on New Year's Day you brought in four, including twins. That was a good way to begin the year!"

"Certainly," chuckled the nurse, "it was a busy time — twenty-one births in six weeks, although as a rule, we average about sixty a year. However, I feel that the prenatal and maternity part of the work is the most important for it gives me a wonderful opportunity to start the health programs early. Otherwise, it often happens that by the time the child is ready to go to school, injurious habits have already been formed."

"How do you know whenever a woman in the countryside is expecting a baby?" asked the fisherman with interest.

"Oh, there are ways," the nurse laughingly rejoined. "The doctor always lets me know as soon as an expectant mother has called on him. In the case of unmarried mothers, it is often the priest or minister who informs me, or it may be a neighbor. After the first baby, the expectant mother usually comes to me voluntarily. Prenatal clinics are not held because I prefer to visit them in their homes and find out under just what conditions the baby must be delivered. I tell them what to do in preparation — how to make the bed up, the washing of the bed-clothes, how to prepare blocks to raise the bed making it easier for those in attendance, and I make certain that the necessities of equipment are available. When the time comes, I go with the doctor to the home, or, as sometimes happens, I have to go alone when the doctor is not available.

"After the baby is born, I visit the mother and baby for a day or two to make sure that all is well and show the mother how to care for her infant. I make a point of seeing each new baby at least once a month. In the outlying districts these visits are combined with school visits, but every Friday afternoon we have a Well Baby Clinic in Baddeck to which the mothers, even those living in the country areas, endeavor to

bring their babies. The doctor is in attendance at this clinic on every fourth Friday. Apart from the regular check-up of the babies, I feel that the mothers gain much from their contact with other mothers.

"By the time the baby is six months old it is both immunized and vaccinated, if possible. At two and four years the child receives reinforcing inoculations. Every effort is made to try to get the mother to have a postnatal check-up at the end of six weeks. So — you see that by making an early beginning, the child should be well on the road to sound health by the time it is of school age."

Smiling across at her companion, the nurse adds: "I seem to have given you a full account of the greater part of our public health program. I believe the only thing I have overlooked is the treatment and follow-up work in connection with any cases of venereal disease that occur in the district—and in this rural community they are comparatively rare."

"You never said a word," observed the man, "about the time you were called to a lumber camp to help a man caught by a falling tree, or when that little child was drowned at Middle River. Oh! I can think of ever so many things you have done that would not come under this general public health program you are telling me about."

"Well," the nurse replied, "I could stay here all morning telling you stories about our 'emergency' work for that is the part of my work that really keeps me on the alert. One never knows what the next hour will bring forth, particularly in a community like this where the doctor and I are expected to cope with all kinds of emergencies. I remember a man coming into the office a few months ago with a nasty gash in his leg. The doctor was away and I was hurrying off to give a hypodermic injection. I did what I could at the time but told the man it might be necessary for him to go to a hospital and have some stitches put in. He didn't like the idea, so I called back to him as I was leaving, 'Well, if you are still here when I get back, I'll see what more can be done for you.' When I returned he was still there so I did my best for him. As he was leaving I said to him, 'Now, Jamie, if that leg bothers you be sure to come in and see the doctor in the morning. If it is all right, then come back in seven days' time and the doctor will take out the stitches.'

"There wasn't a word from Jamie all week but on the seventh day he turned up to have the stitches out. Unfortunately the doctor was away so I urged him to come back the following day. Jamie had travelled a long distance and was determined to have the job over, so he said, 'You put the stitches in, nurse, so why can't you take them out?' What could I do but oblige? The next time I saw Jamie was at a dance and he seemed sprightly enough."

"I think there are a good many people around here that have the same faith in you that Jamie had," said the fisherman. "In the ten years that you have worked among us, you have surely helped many a person over a rough spot."

A blush of gratitude spread over the nurse's face at the unexpected words of appreciation and she in her turn tried to find words to express her kindly feelings toward these people among whom she had so selflessly labored.

"The work has been strenuous and often I have been discouraged, feeling that there was so much more than one person could do but always I have been encouraged by the wonderful spirit of these Scottish people. Even on the stormiest night or in the bleak grey dawn there is always a kindly face and a friendly voice to greet you. Never shall I be able to forget the generous friends by whom I, as a stranger, have been made welcome. It is a good life," said she, slipping in the clutch.

From the nature of human frailty, remedies operate more slowly than disease, and the body itself is slow to grow and quick to decay.—TACITUS

Institutional Nursing

Clinical Teaching in Action

EVELYN TURNER

Average reading time — 8 min. 6 sec.

BECAUSE THE WARD serves as a laboratory for the correlation of theory and practice, its opportunities for learning should challenge the intelligence and resourcefulness of students. It is, thus, through direct contact with patients in actual life situations, that understandings, skills, and the potential qualities of a good nurse can best be developed. Clinical facilities, however, can only become valuable in nursing education when there is effective teaching and supervision and when the administration of the department will allow an organized clinical teaching plan to be carried out.

For the implementation of this program, it is essential that we have a fairly consistent complement of students. In our pediatric department, where we care for children of various ages—i.e., from prematures to fifteen years, who are afflicted with all types of diseases and conditions (except communicable)—our personnel consists of one graduate nurse, twelve student nurses, and one ward maid in addition to the clinical supervisor. The students work an eight-hour day, a six-day week. The graduate, who is conscientious and dependable, acts as assistant to the supervisor and relieves her as necessary, in order that she may devote ample time to clinical teaching.

In order to arrange graduated experience in progressive sequence, during the twelve weeks' period, the supervisor rotates the students within the department. When a block system is not possible, it is desirable to have either one new student each week or two students every two weeks. The following diagram will illustrate the usual placement and rotation of twelve students:

	Number of Students	
General care of toddler and older child	2 or 3	
Nursery	1 or 2	
Milk laboratory	2	1 wk. as Jr. 2nd wk. as senior.

Miss Turner is pediatric service supervisor at the Winnipeg General Hospital.

Graph for Rotation

EACH SPACE REPRESENTS ONE WEEK.

	Gen. Ward	*Nursery*	*Milk Lab.*	*Even. Duty*	*Night Duty*	*Charge Duty*
MISS A						
MISS B						

Evening duty	2	2nd wk. as senior.
Night duty	2	" " "
Charge duty	1 or 2	

We have found that the most opportune time to hold a clinic is immediately following the reading of the night report, that is, between 7:00 and 7:30 a.m. At this time there are fewer interruptions such as doctors, visitors, and other student classes. The corridors seem less obstructed with traffic, especially the stretchers, going to and from the operating-room and x-ray. The telephone does not ring quite so often. With adequate staff one can afford to detain the students from morning care without depleting the nursing service.

A schedule is made out by the supervisor and posted each Saturday, so that the students may have sufficient time to prepare and write out their allotted clinics.

It may be noted here that, when a student is on evening duty, she does not attend clinics, nor does the junior night nurse, as the latter takes care of the patients while the clinic is being held and thus allows the senior night

Sample Clinic Schedule

PEDIATRIC WARD CLINICS—WEEK OF JULY 5, 1948

Date	*Pts. Name*	*Diagnosis*	*Nurses Responsible*	*To include*
July 6 (Tues.)	Ronald Smith	Infantile Eczema	Miss Brown Miss Anderson	Family history Cause Age Symptoms Medical treatment Nursing care Prognosis
July 7 (Wed.)	Gordon Fraser	Anorexia Nervosa	Miss James Miss Roberts	Family history Home management Probable reasons why child could not eat What may be done to correct situation and help the child
July 9 (Fri.)	Garry Long	Pyloric Stenosis	Miss Nichols Miss McDonald	Define Cause Age and sex Symptoms Diagnostic test Medical treatment Surgical treatment Nursing care
July 10 (Sat.)	Ruth Wilson	Collection of urine specimens, (1) test tubes (2) bird-seed container	Miss Armstrong Miss Wood	Have the articles ready to demonstrate both methods and written procedure of each

nurse to participate. Each of the other students prepares and presents one clinic each week.

When there are sufficient students on the department, two students are allotted to the same subject. They study the patient's chart and correlate his or her symptoms with the condition as described in the textbooks. During the morning clinic the supervisor emphasizes the important symptoms, points in nursing care and so on, and, by observing these things in the patient, the student has a vivid picture that should remain fixed in her mind. Essential pediatric conditions, such as pyloric stenosis, are studied at morning clinic whether we have a patient with the condition on the ward at the time or not and, with the aid of colored plates, pictures, lantern slides, and exhibits, a very interesting and educational clinic may be held. We usually post four clinics per week, which seems to be about the right number for our department, as we do not wish to place too heavy a burden on students along with their other responsibilities. It is better to have four clinics well done, than six poorly done. However, on mornings when the students are not scheduled to give a clinic the supervisor may have two of them do a practical demonstration —for instance, a morning sponge—or perhaps prepare a mustard plaster and have the other students evaluate their work. This method seems to stimulate interest and keeps them all on the alert. Besides, the children chosen for such clinics add color to learning by their spontaneous remarks.

All students join in morning discussions. Each is given an opportunity to answer a question before it is answered by the supervisor. If, however, the supervisor feels it will be to the students' advantage to refer to their textbooks for the information, it is left over for another day and it is always interesting to hear the much searched for answer—such answers are not usually forgotten. The written assignments, handed to the supervisor following each clinic, are evaluated, then returned to the student who in turn files them with her pediatric notes for future reference.

The recording of such organized, planned instruction, although time-consuming, is most important. The student is given an experience record on entering the department and she is held responsible for keeping it up to date during the twelve weeks. Procedures are checked off as they are carried out by the student under supervision. Our forms provide space for the name of each patient on whom procedures are carried out, which is helpful to the supervisor when she checks a student's record.

The number of different types of cases cared for and observed during the twelve weeks of training ranges from 130 to 200. Some of the other forms of ward teaching are: orientation to the ward; explanation of ward library; ward routines; experience records; basic procedures; instructions concerning evening, night, and charge duty; discussion of efficiency report; and other forms too numerous to mention. The total number of ward teaching hours are recorded on each student's form, on completion of her experience in the department. Then her record is sent to the nursing education office where the clinical teaching time is transferred to the student's permanent record. The amount of clinical teaching for a student averages twenty-four hours.

The plan for clinical teaching, which must be carefully recorded for each student, provides excellent correlation of theoretical instruction with actual life situations. Where sufficient time for classroom instruction is difficult to obtain, it assures both adequate instruction in pediatric nursing as well as provides a splendid addition to the total course content. It will also be a reserve margin in reciprocal registration and university evaluation, where provincial and university entrance requirements vary widely.

A knocker is all right on a door but everywhere else a nuisance.

Aux Infirmières Canadiennes-Françaises

Nos Enfants

Average reading time — 10 min. 24 sec.

LES ENFANTS ne sont-ils pas les fleurs de l'humanité! Quoi de plus beau qu'un enfant sain, en bonne santé, et y a t'il rien de plus triste qu'un bébé malade? Nous les appelons des noms les plus doux — ange, amour, trésor, et petit chou — mais leur accordons-nous toujours le respect, la considération que l'on doit aux anges, les attentions que réclame l'amour, les précautions dont on entoure sa fortune, et il est bon de se rappeler que le plus petit des vers peut gâter le plus beau des choux.

Dans notre province de Québec, nos mères et nos infirmières aiment bien les enfants. Personne ne peut leur en montrer sur ce point, mais peut-être pouvons-nous apprendre à mieux les soigner et aussi leur prouver encore plus notre amour.

Je recommande aux infirmières, et particulièrement aux institutrices, d'étudier l'intéressant rapport publié par le Ministère de la Santé pour 1947. On y lit à la page 199 que le nombre des naissances a été de 111,288 et le nombre des décès de 6,110 (p. 220). Après le Nouveau-Brunswick, le taux de notre mortalité infantile était le plus élevé du Canada.

Dans un autre tableau (p. 225) l'on donne le taux de mortalité infantile dans les comtés. Quelle étude intéressante pour nos élèves et quel stimulant!

Le rapport de la ville de Montréal (1946) n'est pas moins intéressant, lisez à la page 24 et 25:

Le nombre des décès enregistrés chez les enfants de moins d'un an a été de 1,160 comparativement à 1,351 en 1945, soit une diminution de 191 décès ou de 12.0. La mortalité chez les illégitimes représente une diminution comparativement à 1945: le taux est de 113.4 par 1,000 naissances vivantes en 1946, comparativement à 136.4 en 1945, soit une diminution de 23.0.

Un article paru dans le *Modern Hospital* de janvier, et reproduit en partie et commenté dans *Just Plain Nursing* (Lippincott), m'a paru si à propos que j'ai pensé en faire part aux lectrices de cette page. Une infirmière qui a été témoin d'une épidémie de diarrhée infantile dans une crèche ou une pouponnière n'oubliera jamais la triste expérience dont elle a été témoin. Le spectacle des bébés mourant comme des mouches est en effet inoubliable.

Le Dr. Herman N. Bundesen affirme qu'il n'y aurait pas de telles épidémies ou d'infection si vingt-quatre heures par jour nous appliquions nos connaissances en nursing.

Toutes les personnes prenant soin des bébés devraient avoir la même attitude qu'ont les chirurgiens pour le moindre manquement à la technique et vous connaissez l'adage "Il suffit d'un anneau faible pour faire casser la chaîne." Une seule personne négligente peut être la cause de tout le mal et gâcher le bon travail de toutes les autres.

Le Dr. Bundesen avoue bien franchement que souvent les médecins sont les premiers à manquer à la technique imposée aux infirmières, particulièrement lorsqu'ils refusent de porter un couvre-chef, un masque, ou une blouse. Dans un hôpital, un administrateur disait:

Il est difficile de punir une infirmière pour un petit manquement à la technique quand elle voit que les médecins ne tiennent pas compte des règlements.

Que faut-il penser des visiteurs s'essayant sur les lits, se promenant dans les corridors, et même pénétrant dans la pouponnière si l'on cesse durant une minute de les surveiller. Il y a aussi la parenté dont la tendresse ridicule doit être réprimée. Il faut les persuader d'admirer le

bébé à travers la fenêtre et d'attendre qu'il soit plus fort pour l'embrasser.

L'on ne peut pas nier tout de même que les infirmières font des fautes plus graves que celles-là: jeter des couches souillées sur le plancher au lieu de les déposer dans la poubelle; d'autres contaminent leurs mains en touchant à leur masque ou en s'appuyant sur le bord des berceaux. Ce qui est encore pire, quelques-unes sont négligentes en se lavant les mains. Le lavage des mains est si important, que je cite les recommandations du Dr. Bundesen à ce sujet:

L'infirmière doit se laver les mains: (1) En entrant dans la pouponnière; (2) avant de mettre son couvre-chef et sa blouse; (3) après avoir manipulé un berceau ou la literie; (4) après avoir changé une couche; (5) avant d'aller porter le bébé à la mère; (6) avant de ramener l'enfant à la pouponnière; (7) après s'être servi de son mouchoir ou d'avoir replacé son masque; (8) après avoir époussetter la pouponnière; (9) avant de passer les biberons; (10) après avoir donné un biberon à un bébé ou avant de passer à un autre bébé; (11) après avoir baigné un enfant; (12) avant chaque traitement.

Tous les bébés peuvent être lavés et changés sur la même table si l'on a soin de couvrir la table d'un nouveau piqué ou d'une serviette de papier stérilisé à chaque bébé. Tout de même, l'on considère que la technique est meilleure si les enfants sont changés de couche dans leur bassinette.

Il est recommandé que l'infirmière, chargée de changer les bébés, ne s'occupe pas des biberons, mais, si la chose est impossible, toutes les couches devraient être changées avant que les bébés soient passés aux mères ou reçoivent leurs biberons.

Concernant le personnel des pouponnières, voici ce que Dr. Bundensen demande:

1. Le jour comme la nuit, il doit toujours y avoir une infirmière diplômée enregistrée en service actif au département de l'obstétrique.

2. Dans la pouponnière, il doit toujours y avoir *une infirmière pour huit bébés* et dans la pouponnière d'isolement au moins *une infirmière pour quatre nourissons.*

3. La surveillante des pouponnières doit toujours être *une infirmière diplômée ayant reçu une formation spéciale* concernant les soins à donner aux nouveaux-nés.

4. Il doit y avoir un personnel auxiliaire assez nombreux pour tenir le département des pouponnières propre et hygiénique.

Le personnel mentionné dans la première de ces recommandations est désespérément insuffisant. Il faut bien admettre tout de même que dans bien des hôpitaux le département de l'obstétrique est confié à des élèves qui reçoivent peu ou pas de surveillance. Le nombre d'infirmières recommandé dans les pouponnières n'est pas trop élevé. Il est encourageant de constater qu'une infirmière diplômée spécialisée est recommandée pour prendre charge, en tout temps, de la surveillance des pouponnières. La surveillance des pouponnières le jour comme la nuit est des plus importantes, d'autant plus que l'emploi des aides dans les pouponnières est assez répandu. Cependant il y a des hôpitaux qui se plaignent de ne pouvoir trouver d'infirmières qualifiées voulant accepter l'emploi de surveillante dans ce service. Voilà un autre domaine professionnel où il y a beaucoup d'appelées.

— SUZANNE GIROUX

℞ *Chuckles* P.R.N.

Photophobia is marked fear of having one's picture taken.

Constipation is due to a lack of refuge.

Salpingitis means inflammation of the salpin.

Peripheral means pertaining to the perineum.

Cirrhosis is the discharge of cerumen.

Basal metabolism is breaking and rebuilding of the tissues along the basal canal.

An adjuvant is a joining together of parts.

A cautery pertains to the tail-bone.

Waste water from a bath is conducted along various pipes to a sewage farm where it is collected in a bed.

Trends in Nursing

Average reading time — 10 min. 24 sec.

Mental Health

The World Federation for Mental Health, representing twenty-one countries, organized in the summer of 1948, has designated the National Committee for Mental Hygiene (Canada) as the convening organization in this country. A meeting to discuss implications for Canada of the World Federation was held recently in Toronto. The 1948 Congress in London was the third international meeting on the general topic of mental hygiene. The outstanding difference of this conference was that, instead of papers by individuals, a large number of discussion groups were organized in many countries. These groups comprised representatives of several disciplines such as psychiatry, psychology, education, etc. Various aspects of the one general topic — e.g., relationship of mental health to world citizenship — were discussed and the group report forwarded to a central office in London, England. Three hundred reports from twenty-four countries were analysed and digested by an international preparatory commission, representing psychiatry and social sciences in ten different countries. This report which was very definitely the product of group thinking was presented and finally adopted by the Congress. During the first four days of the Congress, child psychiatry and medical psychotherapy were the topics of discussion. In the last six days, mental hygiene was studied under the following headings:

Problems of World Citizenship and Good Group Relations between Individuals and Society; Family Problems and Psychological Disturbances; Mental Hygiene in Industry and Industrial Relations; and Planning for Mental Health.

Membership in the World Health Organization will be open to any society or association concerned with mental health and human relations, in any country eligible for membership in the United Nations. The headquarters office will be in Switzerland. UNESCO and WHO have extended World Federation their official recognition as the appropriate non-governmental, international consultative body in mental health. The report on the Mental Health Congress in London appeared in *Survey Graphic*, October, 1948; reprints are available.

Voluntary Societies and Health

"Health Education to be fully effective must be democratic." This quotation from the editorial in March-April, 1949, issue of *Health* is worth repeating because there appears to be evidence that this concept is in some danger of being forgotten. This editorial describes the voluntary society as the best agency for creating public opinion favorable to government action conceived in the interests of "John Citizen's Health." "With the powerful movement evident toward socialism in so many countries, there is a great danger that the importance of the voluntary association will be forgotten and few people realize that this means that democracy itself may be forgotten." There is a message in this article for Canadian nurses.

New Pasteurization Legislation

We read in *Health* that within a week of one another, laws for the compulsory pasteurization of milk are being introduced in England and in Saskatchewan. *Health* goes on to repeat the message that, in spite of the "proven benefits," such legislation has been delayed over the years by governments' fear of adverse reaction from the voting public. Congratulations are extended to Great Britain and Saskatchewan for following the lead of Ontario and giving an example to the rest of the world.

Better Use of Nursing Personnel

Canadian nurses are asking many of the questions raised and answered in an article appearing in the March number of *The Modern Hospital.* After you have read this brief review you will, we hope, seek for and read the original article. The article tells of a study made in several public health service hospitals which indicated that the basic need was the development of a program for more efficient and economical utilization of the nursing service personnel. This was a group project and included the division of hospitals headquarters staff members, an expert in job analysis, an outstanding director of a school of nursing, an administrator of a civilian hospital, and the executive secretary of the Association of Practical Nurse Education. One hospital was used for survey purposes.

It was shown by the analysis that 46 to 52 per cent of professional nurses' time was being used for non-professional activities. Need for improved ward administration and supervision, for revision of nursing service policies and procedures, and for a re-arrangement of activity schedules and hours of duty were noted.

As a result, pertinent questions were raised and, in an attempt to find the answers, a more intensive study was instituted.

The initial step in procedure was the appointment of an executive committee at headquarters office to co-ordinate the necessary reorganization of the nursing service.

The medical director and director of nursing service met with the committee to formulate a plan of action. Next, a working committee comprised of assistants to the director of nursing service, the head nurses, chief dietitian, and executive housekeeper was organized to develop a plan for reorganization. To review the progress and development of the working committee, and approve and put into operation changes proposed, the administrative committee was organized at the hospital.

The working committee began by stating the aims of the nursing service, then established premises as guides for allocating the activities: (1) The responsibilities of the professional nurse. (2) What the professional nurse would do. (3) What the trained practical nurse would do. (4) What attendants would do. The reallocation of nursing and related activities was only one part of the development of the plan for the reorganization of nursing service. It was also necessary to determine the numbers of the various types of employees needed and how they were to perform their activities.

Additional consultants were appointed to make a complete survey of the hospital. The report of the survey was used as a guide to develop a manual of routine and ward or nursing service policies. After the reallocation of nursing and related activities, the next step was to determine how each procedure should be performed. After the completion of the study a plan for reorganization of nursing service was developed. Among other changes, six ward clerks were appointed and given training on the job. Additional appointments have been made in the patients' clothes room so that all checking is done in this unit instead of in the wards. A clerk stenographer was appointed to the nursing office to relieve the nursing service assistants of clerical duties.

The second and third phases of the plan have yet to be completed. The manuals of nursing procedures and ward policies have been prepared in loose-leaf form and a copy forwarded to every hospital in the service.

Hospital Moves into the Home

"Home care for patients who are suitable is not only as good as hospital care, it is infinitely better, for in a hospital, a patient is one of many." This quotation is attributed to Dr. Martin Cherkasky, executive of the Home Care Department of Montefiore Hospital in New York. The Home Care Plan evolved at Montefiore in answer to the problem

of waiting patients and shortage of hospital beds. The solution — to transfer the patient to his own bed and take the hospital to him — has worked extremely well. The patients chosen for the initial experiment were mostly those suffering with long term illnesses, many of them cancer patients. The New York Cancer Committee, on being approached, authorized a pilot project for home care of cancer patients and granted the hospital an initial sum of money. Dr. Cherkasky was chosen to direct the project and set up the procedures to be followed:

A. *Determining factors in selection of patients* — (1) patient no longer requires specialized hospital facilities; (2) social eligibility decided by social worker after conference with patient and family; (3) distance of home from hospital; (4) basic requirements in home; (5) home atmosphere and family health; (6) patient's desire for home care.

B. *Implementation* — (1) hospital equipment provided as needed; (2) a. patient to receive regular visits from physician; b. doctor on call for emergencies 24 hours per day; c. specialists on staff available; (3) public health nurse to give nursing care; (4) social service worker to keep contact with patient and family; (5) children — arrangements made with board of education for visiting teacher.

Directors of home care plan have found that patients do well, are happier and, in the case of terminal illness, the families are better satisfied. The service has been extended to include other chronic illness such as heart diseases, vascular disease, neurological disturbances, etc.

The success of the experiment has resulted in this plan being extended to five hospitals functioning under the city of New York.

What is the saving to the hospital? Montefiore reports that the difference in favor of home care is from $9.00 to $10 per day. Dr. Bluestone believes:

We have oversold the hospital to the people to the point where we are unable to shoulder the financial consequences. The road back is fortunately easy and inexpensive where the home environment is favorable or can be made so for the patient.—*R. N.* March, 1949.

Rural Adventure

A description of a partnership between a rural medical centre and a metropolitan university affiliated medical centre is to be found in *Hospital Management*, March, 1949. Hunterdon County, N.J., with a population of 38,000, is building its first hospital. The new medical centre will provide a 125-bed hospital and will include a health centre unit. It will be closely associated with a large urban teaching centre. The plan will be administered under the Regional Hospital Plan, a teaching program for rural and suburban hospitals financed by the Kellogg Foundation, and will include provision for a member of the teaching staff of New York University-Bellevue to sit on the Medical Board of the Hunterdon Centre. Chiefs of service of the Hunterdon hospital will have academic rank on the New York University faculty and faculty specialists in New York can be called for difficult cases. Senior undergraduate medical students will spend some time at Hunterdon and resident doctors from University Hospital and Hunterdon will rotate. The new Hunterdon school of nursing will be affiliated with Bellevue school of nursing and trainees will spend part of their training period at the Medical Centre. It is hoped that a very close contact between the two institutions will be maintained at all levels in order to successfully reach the goal — — i.e., better health for the citizens of Hunterdon, greater facilities for the prevention and control of disease, and increased educational facilities for medical and nursing students.

Digest

Copies of a *Digest of Provincial Board Rules and Nurse Registration Acts* are now available through the Canadian Nurses' Association, Suite 401, 1411 Crescent St., Montreal 25. The price is ten cents per copy.

Orientation et Tendances en Nursing

L'Hygiène Mentale

L'hygiène mentale est à l'ordre du jour. Vingt-et-un pays se sont organisés en fédération en 1948 dans le but d'étudier la santé mentale. Cette fédération a désigné le Comité National Canadien d'Hygiène Mentale pour organiser le même mouvement dans notre pays. Le nouveau comité a tenu une séance dernièrement dans le but de discuter la part que prendra le Canada dans la prévention des maladies mentales.

Pour la troisième fois se tenait à Londres, en 1948, un congrès international sur les questions d'hygiène mentale. Ce congrès fut bien différent des autres. Au lieu de lire des travaux, comme il est généralement fait dans ce genre de congrès, des représentants de différents pays formèrent des groupes et discutèrent des différents problèmes d'hygiène mentale. Parmi ces groupes, il y avait des spécialistes en psychiatrie, en psychologie, en éducation, etc. Trois cents rapports présentés par vingt-quatre pays furent analysés par un comité spécial, formé de psychiatres et de sociologues de dix pays. Ce comité présenta un rapport qui fut adopté par le congrès.

Durant les quatre premiers jours, la psychiatrie chez l'enfant et psychothérapie médicale furent l'objet de la discussion. Durant les six derniers jours, l'on étudia l'hygiène mentale. Les questions suivantes furent discutées: Les problèmes de l'homme comme citoyen du monde; les bonnes relations entre les groupes et les individus; problèmes et troubles psychologiques; l'hygiène mentale et les relations industrielles.

Projets en hygiène mentale: Les pays éligibles à la Société des Nations peuvent bénéficier de tous les travaux de l'Organisation Mondiale de la Santé de nature à améliorer les rapports sociaux.

La démocratie et l'enseignement de l'hygiène: Si l'on veut que l'enseignement de l'hygiène donne de bons résultats, il ne faut pas oublier que les sociétés bénévoles sont les agents par excellence pour créer l'opinion publique. Si les sociétés bénévoles sont déjà en faveur des lois et des mesures que prend le gouvernement pour protéger la santé de ses administrés, elles seront mieux accueillies. Actuellement, il y a une tendance dans les pays, à tout socialiser, l'on est porté à oublier le rôle des sociétés bénévoles et souvent même à oublier les principes démocratiques.

Cet avertissement, donné dans le numéro de mars-avril de *Health*, s'adresse aux infirmières comme aux autres.

La Pasteurisation du Lait—Force de Loi

Dans *Health*, nous lisons que la pasteurisation du lait en Angleterre et en Saskatchewan est obligatoire. Une telle loi, bien que reconnue nécessaire depuis nombre d'années, n'avait pas encore été votée par crainte des réactions des électeurs. Des félicitations sont offertes à la Grande-Bretagne et la Saskatchewan pour avoir suivi l'exemple de l'Ontario.

Meilleure Utilisation des Services de l'Infirmière

Ne manquez pas de lire dans le *Modern Hospital* de mars, l'article sur une étude faite dans plusieurs hôpitaux sur l'utilisation des services de l'infirmière. L'on en est venu à la conclusion qu'il fallait préparer un programme bien défini démontrant comment utiliser les services du personnel.

Le groupe, ayant fait cette étude, était composé d'un expert en analyse du travail, d'une directrice d'école d'infirmières, d'un administrateur d'un hôpital, et de la secrétaire de l'Association of Practical Nurse Education.

Un hôpital fut choisi pour faire l'étude. Il fut démontré, d'après l'analyse du travail, que 46 pour cent du temps de l'infirmière était employé à exécuter un travail qui ne demandait pas de formation professionnelle. L'on nota la nécessité d'améliorer l'administration et la surveillance des départements, de changer notre ligne de conduite concernant les services des infirmières, de réorganiser les heures de service et les diverses activités d'un département de malades.

A la suite de cette étude, bien des questions se posèrent et, pour en trouver les réponses, une nouvelle étude fut jugée nécessaire. L'on commença par former un comité dans le but de co-ordiner la réorganisation des services des infirmières. Un plan fut préparé par le directeur médical et la directrice du nursing. Un autre comité, dit du travail, composé des assistantes de la directrice du nursing, des hospitalières, de la diététiste en chef, et de la surveillante des domestiques, fut formé pour préparer le plan de réorganisation.

Le comité du travail présenta les rapports de ses activités, de ses progrès, fit des suggestions à un groupe d'administrateurs chargé de les étudier, de les approuver, et de les mettre à exécution.

Le comité du travail commença par établir les buts du service hospitalier et, en guise d'introduction, afin de bien diriger les activités, il établit: (1) Les responsabilités de l'infirmière professionnelle; (2) ce que l'infirmière professionnelle devrait faire; (3) ce que l'aide (practical nurse) devrait faire; (4) ce que les filles de salle devraient faire. Cette répartition des attributions de chacun des groupes ne fut qu'une partie de la réorganisation des services hospitaliers.

Il fut aussi nécessaire de déterminer le nombre d'employés de chacune de ces catégories jugés nécessaires et comment ils devraient s'y prendre pour exécuter leur travail. Des consultants ou experts furent ajoutés à ce comité pour faire une enquête complète sur l'hôpital. Le rapport de cette enquête servit de guide dans la préparation d'un coutumier (ward manual).

Voici quelques-uns des changements survenus à la suite de la réorganisation des services des infirmières: Six commis furent nommés dans les salles et apprirent à faire leur travail sur les lieux. L'on augmenta le personnel du vestiaire, afin que tout le contrôle des vêtements des malades soit fait là plutôt que dans les salles. Une sténographe fut attachée au bureau de la directrice du nursing, afin de diminuer le travail d'écriture des assistantes.

L'Hôpital Déménage à la Maison

"Lorsque l'état d'un malade lui permet de rester à la maison, les soins que l'on peut lui donner sont non seulement aussi bons que les soins donnés à l'hôpital, mais ils sont infiniment meilleurs car, à l'hôpital, il n'est qu'un dans la foule anonyme des malades." Cette citation est attribuée au Dr. Martin Cherkasky, directeur du département des soins donnés à domicile de l'Hôpital Montefiore de New-York. Ce nouveau genre de service à domicile est la solution trouvée par l'Hôpital Montefiore pour obvier à la pénurie de lits d'hôpitaux. Au début de cette expérience, l'on a choisi surtout des malades chroniques, entre autre plusieurs cancéreux. La Société du Cancer de New-York a trouvé l'expérience très intéressante et a donné un octroi à l'hôpital pour le soin des cancéreux à domicile.

Le Dr. Cherkasky a déterminé la méthode à suivre dans le choix des malades: A. (1) Le malade n'a pas besoin de soins spéciaux à l'hôpital; (2) l'auxiliaire sociale détermine, après une entrevue avec la famille et le malade, si ce dernier a droit à ces services; (3) la distance entre l'hôpital et la demeure du malade; (4) les facilités existantes dans la maison; (5) l'atmosphère et la santé familiale; (6) le désir du malade de demeurer à la maison. B. Engagement de l'hôpital— (1) Fournir l'outillage nécessaire; (2) (a) visites régulières du médecin, (b) médecin à la disposition des malades vingt-quatre heures par jour en cas d'urgence, (c) les spécialistes de l'hôpital sont à la disposition des malades; (3) les infirmières visiteuses donnent les soins aux malades; (4) l'auxiliaire sociale continue de visiter la famille et le malade; (5) lorsque les malades sont des enfants, une institutrice les visite, grâce à une entente avec le département de l'éducation.

Les directeurs de ce service ont trouvé que les malades étaient satisfaits, plus heureux et, lorsque cette maladie est la dernière, les familles ont la satisfaction du devoir accompli. Ce service a pris soin de malades souffrant de troubles cardiaques, vasculaire, neurologiques, etc.

Le succès de cette expérience a été tel que cinq hôpitaux de New-York ont adopté ce système de service à domicile. Quels bénéfices en retire l'hôpital? L'hôpital débourse $9.00 à $10.00 de moins chaque jour pour le malade traité à la maison que pour celui qui l'est à l'hôpital. Le Dr. Bluestone croit que nous avons surestimés la valeur des services de l'hôpital et la vente en a été faite au point qu'il est impossible d'en supporter les conséquences financières. Heureusement qu'il est facile de faire chemin en arrière sans grandes dépenses là où le milieux familial est bon et peut convenir au malade.

Aventures Rurales

Un centre médical rural est l'entreprise décrite dans *Hospital Management* de mars, 1949. Le comté de Hunterdon dans New-Jersey, population de 38,000 habitants, aura son centre médical. A côté d'un hôpital de 125 lits, il y aura une unité sanitaire. L'enseignement de l'hygiène à la population se fera sur une grande échelle.

Ce projet sera administré par Regional Hospital Plan, organisme ayant pour but de réaliser un programme d'enseignement pour les hôpitaux ruraux et dont les frais sont

supportés par la Kellogg Foundation. Un membre de la faculté de New York University-Bellevue fera partie du conseil médical du centre médical de Hunterdon. Les spécialistes de New-York seront appelés dans les cas difficiles. Les étudiants en médecine feront en dernière année un stage à Hunterdon et les médecins résidents de l'hôpital universitaire et celui de Hunterdon feront la rotation entre les deux hôpitaux. L'école d'infirmières de Hunterdon sera affiliée à celle de Bellevue et les élèves des deux écoles feront également un stage dans ce centre médical.

L'on espère, comme résultat de cette expérience, que les deux institutions seront toujours au même niveau scientifique, que les citoyens du comté de Hunterdon jouiront d'une meilleure santé par ce qu'il leur sera plus facile de prévenir les maladies et que les étudiants en médecine et les élèves infirmières bénéficieront de leur expérience dans un milieu rural.

Compilation

Une compilation des diverses lois et règlements des associations des infirmières des diverses provinces du Canada a été préparée par l'Association des Infirmières du Canada, chambre 401, 1411 rue Crescent, Montréal 25, à 10 cents l'exemplaire.

Cancer Among Children

With the continued and drastic reduction in childhood mortality from the infections, there has been a radical change in the relative importance of deaths from cancer among children. This is clearly observed in the data for children insured in the Industrial Department of the Metropolitan Life Insurance Company. At ages 1 to 14 combined, cancer, including leukemia and Hodgkin's disease, now is the second ranking cause of death from disease, and at 5 to 9 leads all other diseases. As recently as 1930, cancer was not even among the first 10 causes of death among children. In 1946-47, cancer accounted for one out of every nine deaths from diseases at ages 1 to 14, whereas in 1930 it was responsible for only one in every 50 such deaths. The rise was slightly greater for boys than for girls — 42 per cent and 36 per cent. The death rate among boys is now nearly one-third higher than among girls.

Leukemia is the most common type of fatal cancer in children. It accounts for nearly one-half of the cancer deaths at 1 to 4, for a little more than two-fifths at ages 5 to 9, and somewhat over one-third at 10 to 14, Cancer of the bladder and kidney now ranks second at ages 1 to 4, but it declines rapidly in relative importance with advance in age. The brain is third in the list at the preschool ages, but is second at age periods 5 to 9 and 10 to 14. At 5 to 9 years, brain cancer accounts for more than one-fifth of the total mortality from malignant diseases. Cancer of the bone features prominently in later childhood. Hodgkin's disease constitutes a relatively unimportant part of the total.

While the figures on cancer in childhood do not make cheerful reading, the situation looks worse than it really is. Actually, a part of the recorded increase in the mortality from cancer in childhood is probably spurious. It reflects more accurate diagnosis, with the result that cancer is now being reported on death certificates in increasing numbers. The general air of pessimism which has prevailed in the past with regard to the prognosis for many types of cancer in childhood is gradually lifting. An increased proportion of children with cancer are now receiving medical attention in the early stages of the disease rather than after long periods of delay, as was formerly the case; and an increasing number of children are surviving five and ten years after treatment, according to reports in the medical literature.

The prominence of cancer as a cause of death in children clearly points to the need for increased attention to this problem in the cancer control program. Specific procedures for the early diagnosis of cancer, which are suitable for this age period of life, must be developed. Parents should be educated to extend health supervision for their children well beyond the period of infancy, in order to give physicians greater opportunity to detect early cases. Certainly, a greater readiness on the part of physicians to investigate apparently harmless growths and swellings in children is in order. Efforts should be directed toward familiarizing parents and teachers with the abnormal physical signs and with symptoms, such as unusual mental or emotional behavior, which may give the first clues to the presence of brain tumors in children.

— *M.L.I.C. Statistical Bulletin*

In Memoriam

Ada Elizabeth Chisholm, who graduated from the Montreal Woman's Hospital in 1912, died in Montreal on March 3, 1949, after an illness of eight months. Mrs. Chisholm practised as a private duty nurse in Montreal and received the King George V Silver Jubilee Medal in 1935. She was an active member and past president of the alumnae association and retired from nursing about ten years ago.

* * *

Mary Ellie Clark, who was formerly on the staff of Christie St. Hospital, Toronto, died at Uxbridge, Ont., on March 5, 1949.

* * *

Sophia Rebecca Doherty, a graduate of the Royal Victoria Hospital, Barrie, Ont., over forty years ago, died on March 19, 1949, after a year's illness. After graduation, Miss Doherty worked at Bellevue Hospital, New York, then returned to Collingwood, Ont., where for many years she served as night supervisor at the General and Marine Hospital.

* * *

Janet Hudson Forbes, who graduated from Riverdale Isolation Hospital, Toronto, in 1933, died on March 2, 1949, following a brief illness. Miss Forbes had been on the staff of her home hospital since 1934.

* * *

Annie Mabel Foster, who graduated from Wellesley Hospital, Toronto, died at Belleville, Ont., on February 18, 1949, in her fifty-seventh year. Miss Foster served as a nursing sister with the C.A.M.C. during World War I, serving at Orpington Hospital, England. She returned home in 1919 and was in indifferent health for the rest of her lifetime.

* * *

Winnifred Harvey, who graduated from the Winnipeg General Hospital in 1909, died at Crockett, Calif., in December, 1948.

* * *

Matilda Ann (Cornell) McArthur, who graduated from St. Thomas's Hospital, London, at a time when Florence Nightingale was still directing the school of nursing, died in Montreal on April 16, 1949, at the age of ninety-four.

* * *

Marjorie Maxime McCulloch died in Winnipeg on March 14, 1949. During World War II Miss McCulloch served overseas with No. 5 C.G.H. in England, Sicily, France, and Belgium.

* * *

Charlotte (Kettles) Millar, who graduated from the Brandon General Hospital in 1909, died in Ottawa on February 28, 1949, in her seventy-second year. During World War I, Mrs. Millar served in the European theatre, later serving at Virden and Dauphin hospitals in Manitoba. She was married in 1939.

* * *

Florence M. Read, a graduate of the Montreal General Hospital, died on April 14, 1949, at the age of sixty-five.

* * *

Nancy Agnes (Smith) Robinson, who graduated from St. Joseph's Hospital, Victoria, in 1930, died in Victoria on March 19, 1949, following a lengthy illness. She was thirty-nine. Following graduation Mrs. Robinson worked in the hospitals in Ocean Falls and Invermere, B.C., and at St. Joseph's.

* * *

Olivia Smith died in Edmonton on February 20, 1949, at the age of eighty years. Miss Smith's nursing career took her to many corners of the world. Twenty years ago she made her home in Edmonton where she continued to work until failing eyesight curbed her activity two years ago.

* * *

Lisle (Barr) Walden, who graduated from the Toronto General Hospital in 1919, died at Lindsay, Ont., on February 24, 1949.

* * *

Barbara (Kennedy) Wilson, who graduated in 1924 from the Toronto General Hospital, died in October, 1948.

* * *

Jessie Wilson, who graduated from the Winnipeg General Hospital in 1922, died in 1948.

Whenever you are to do a thing, though it can never be known but to yourself, ask yourself how you would act were all the world looking at you, and act accordingly.—THOMAS JEFFERSON

Student Nurses

Nephrectomy

MARGARET M. BROWN

Average reading time — 8 min. 48 sec.

MARILYN, a little Canadian girl, four and one-half years old, is an only child, which may account to some extent for her retiring disposition and shy manner. In addition to this, her history of enuresis has made her particularly self-conscious and withdrawn. It is fortunate that Marilyn's mother has been tactful and not overly sympathetic or indulgent with the child. Rather, she has taught Marilyn to rightly accept her condition with the hope that some day, as the doctor has said, she will be like other little girls. Marilyn is not a pretty child, but when her soft blonde hair is tied in French braids with little pink bows she looks quite attractive in a demure sort of way. After nearly a month of association, shy smiles and the occasional short talk about her dolly or music-box radio were the extent of our friendship. My reward on the day previous to discharge was ample. Still in the same shy way she said, "You know, nurse, I'm going to miss you!"

On August 22, Marilyn was admitted to the ward with a history of enuresis and non-functioning left kidney. She had been admitted for a cystoscopy and pyelography and was to remain for investigation. Naturally, Marilyn cried for her Mommy at first but when it was explained that Mommy could visit her, she soon settled down to life in her little cubicle.

The day following admission a cystoscopy and pyelography was done. Results from this showed the following:

Bladder specimen — normal, but with plus 2 albumin. Ureter specimens showed:

Right		*Left*
Cloudy	Appearance	Clear
Blue	Color	Colorless
0	Casts	0
plus 1	Polymorphs.	plus 2
plus 1	Red cells	occ.
plus 2	Epithelial cells	plus 1
0	Bacteria	0
0	Crystals	0

From this it is quite evident that the injected dye had not entered the left ureter and that, therefore, there was some obstruction.

At this time penicillin 25,000 units q.3.h. was ordered to combat any infection and also sulfadiazine ½ tablet, given t.i.d., p.c. Fluids were given in abundance to flush out the kidneys and to prevent the formation of any sulfa crystals in the urine. To further check on the possible presence of crystals, daily specimens were sent to the laboratory for analysis. Results from these were essentially negative. The nursing care at this time consisted of a careful record of the daily fluid intake and output, and offering water and sweetened fruit juices at frequent intervals. Marilyn was very co-operative about drinking lots of water, and she took the penicillin injections very bravely although she dreaded the sight of the needle. One of the biggest problems with Marilyn was keeping the bed dry and preventing a buttocks' rash from irritation of the skin, due to the escaping urine. The best we could do was to change the linen frequently and to prevent any rash by massaging with alcohol and powdering her back. Streptomycin was ordered

Miss Brown is a student at the Vancouver General Hospital.

later to enhance the action of penicillin and to act more specifically against other organisms. The dosage was 100,000 units q.3.h. Poor Marilyn! This meant an injection in either hip every three hours.

After over a week of investigation and observation it was decided that Marilyn should undergo an operation. Indications for the operation were:

1. Recurrent attacks of pyelitis with spiking temperatures.
2. I.V. pyelogram showed a non-functioning left kidney.
3. Retrograde study showed dilated calyces, dilated pelvis, and a dilated tortuous ureter on the left side.

Marilyn was told the night before operation, when the usual pre-operative nursing care was being done, that the doctor was going to operate in the morning. Pre-operative treatment was:

1. An S.S. enema to evacuate the bowels, thus minimizing the danger of distension post-operatively and to prevent contamination of the operating-room set-up by involuntary defecation.
2. A local skin preparation for a left nephrectomy. This is quite an extensive preparation. It consists of shaving the back from the buttocks to the shoulder blades on both sides, around to the midline of the chest and abdomen on the operative side from the left nipple to the left groin.
3. A pre-operative urine specimen was sent to the laboratory. Results from this were negative except for albumin plus 1 and white blood cells plus 4. From blood work done on admission it was found that the hemoglobin was 71%. At this time, blood grouping and typing were done.

The operation report read as follows:

Under general anesthetic the usual nephrectomy incision was made. Kidney adhesions were separated and the kidney freed. The ureter was found long and redundant. The renal pedicle was clamped and tied with No. 2 catgut and the liberated kidney removed attached to the ureter. The ureter itself was traced down as low as possible and severed. The distal stump was ligated and carbolized. Two cigarette drains were placed in the deep part of the wound. Penicillin powder was sprinkled in this area and the wound closed in layers, using three wire sutures through and through.

Upon return to the ward, having regained consciousness in the post-anesthetic room, Marilyn was made more comfortable by having her face and hands washed, her hair combed back neatly, and her back gently massaged. The dressing to the incision was changed as there was a moderate amount of sero-sanguinous discharge. Penicillin was recommended q.3.h., and to counteract fluid loss 500 cc. of glucose and saline were commenced intravenously. Morphine gr. 1/48 was given hypodermically three hours after return to the ward to allay restlessness. A blood transfusion was given in the operating-room and repeated later on the ward. Daily intravenouses were given for four days to supply extra fluid and nourishment. As Marilyn's lips were becoming dry and sore, frequent applications of zinc oxide ointment were necessary. This soothed and moistened the lips and soon the condition cleared.

Involuntary micturitions decreased to a great extent post-operatively. To diminish the incontinence still more, a regular system was started whereby a pan was offered to Marilyn every hour, then every two hours. In this way a training program was gradually developed and proved quite successful.

Because of this involuntary voiding it was most essential to give special care to the buttocks. This was done frequently, using mainly alcohol and powder.

As there was only a slight amount of discharge from the incision, the dressing was changed only as necessary. On the third day Dr. L removed the drains and applied a dry dressing. This removal was followed by a slight elevation of temperature but it was felt that the penicillin therapy would combat any infection. This it did, for the temperature became

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normal by the next night. On the same day an S.S. enema was given routinely with good results. In the afternoon Marilyn was allowed to sit up in bed supported by pillows. How pleased she was!

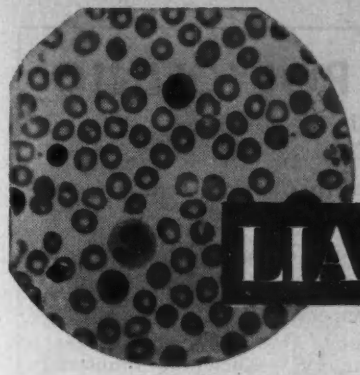
At Dr. L's next visit the dressing was completely removed and only sulfamel and sulfa powder applied to the incision. The argument for this was that the dressings would be contaminated in any case by urine. At this point Mandelamine tablets ii were ordered t.i.d. and ii h.s. These tablets are urinary antiseptics and were a further precaution and treatment for infection. Urinalyses post-operatively were still essentially negative.

Five days post-operatively Marilyn was allowed up in a chair to her great satisfaction! Her recovery was progressing favorably. Catheterization for residual urine produced only one ounce and training on the pan was satisfactory. On September 7, all dermal sutures were removed and two days later all wire sutures. The following day, however, a small serous area ruptured at the centre of the incision. At Dr. L's order, we immediately began applying hot magnesium sulphate fomentations. At this time an order for the instillation of 10 cc. of neo-silvol into the urinary bladder was carried out to prevent infection.

Within three days the incision was again clean and dry. All medications and treatments were then discontinued. Marilyn was definitely improved. On September 16, we said good-bye to her as she was wheeled out in her chair, wearing a beaming smile and clutching the inevitable red balloon and radio.

Diet in Urogenital Disorders

Writing on this topic in a recent issue of *The Urologic and Cutaneous Review*, Dr. Carl E. Burkland of Sacramento, Calif., stated that "placing patients upon a diet free of condiments, spices, alcohol, coffee, tea, cocoa, chocolate, and the carbonated beverages, such



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SQUIBB MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

as the cola drinks, has made them much more comfortable and has hastened or caused the recovery from their illness to a marked degree." "A highly acid urine is more irritating than an alkaline one and the use of a diet having a high alkaline ash when indicated is very beneficial. Such a non-irritating diet, together with the drinking of large amounts of water and/or fruit juices, is very soothing to the inflamed mucosa of the urogenital tract."

"The caffeine and carbonated beverages, alcohol, the condiments and spices increase urinary frequency and dysuria probably in two main ways: First, by acting as diuretics to increase the amount of urine produced and, secondly, as direct irritants to already infected, inflamed or irritated mucosa. Coffee appears to be the biggest offender . . . largely because of its widespread use." Dr. Burkland indicates that its action is largely dependent on its high content of caffeine, there being about 1½ grains of caffeine in the average cup. This caffeine acts as a central nervous system stimulant and a diuretic. Cocoa containing theobromine is also a powerful diuretic and tea contains both caffeine and theobromine. The cola drinks contain considerable caffeine and some theobromine, while ginger ale contains the irritating spice—ginger.

Among condiments, Dr. Burkland includes bottle sauces, catsup, horse radish, mustard, pepper, spices, and vinegar. The chief spices causing irritation are pimento, ginger, nutmeg, sage, anise, and cinnamon.

"The diuretic action of alcohol is due to a dilator effect on the renal vessels and local irritation of the renal cells but mainly to the excessive ingestion of fluid associated with its use. Champagne is the most irritating, then beer, gin, effervescent wines, whiskey, and still wines."

"This dietary regimen has been particularly of value in cutting down the frequency, urgency, burning, and general urinary distress." "The drinking of large amounts of water daily, unless there are cardiac or renal contra-indications, is very beneficial to a patient with any genito-urinary inflammation or irritation . . . Thirst is no index of the water needs of the body because the urge to drink varies according to climate and activity and is insufficient to keep the body in an optimal state of hydration . . . If the population at large drank from two to three litres of water daily, physicians would have fewer cases of infection and calculus formation to treat."

A man seldom thinks with more earnestness of anything than he does his dinner.

— SAMUEL JOHNSON

Book Reviews

Venereal Disease, Its Prevention and Conquest, by George Ryley Scott, F.Ph.S. (Eng.), F.Z.S. 80 pages. Published by Torchstream Books, 50 Alexandra Rd., London S.W.19, Eng. 2nd Ed. 1947. Price 3s. 6d.

Reviewed by Dorothy Cox, V.D. Division, P.E.I. Department of Health and Welfare.

This is the second edition of a book which was first published in England in 1944. It adds little, if anything, to the volume of literature already published on the subject, with the exception of two chapters on prophylaxis—the author's solution to the problem of V.D. control. Though prophylaxis is undoubtedly of some benefit, it is at best a very controversial subject at the present time and the author admits that, in order to be effective, it must be carried out promptly and thoroughly. He makes little of the fact that many people are under the influence of liquor at the time of exposure and in no condition to submit to any procedure.

In all fairness, it must be said that the fact that this book was written and published in England makes much of it inapplicable to this country. We in Canada have been particularly fortunate in our V.D. control program, with its notification of cases, free treatment, contact investigation, confidential and sympathetic attitude towards patients and contacts, public education, and the rapid development of new methods of treatment—all of which have brought about a steady decrease in our rate of infection.

The success of our program here, which has the support of the church as well as of the medical profession, makes it difficult for us to understand the author's attitude towards the moral and social aspects of V.D. control, compulsory treatment, investigation of contacts, and the new methods of treatment. It would seem unwise to emphasize prophylaxis and endanger the relationship now existing among all sections of our population.

District Nursing, by Eleanor J. Merry, S.R.N., and Iris D. Irven, S.R.N. 266 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1948. Illustrated. Price $3.25.

Reviewed by Katherine Weatherhead, Educational Director, Central Division, Montreal Branch, Victorian Order of Nurses.

"District Nursing" is a practical reference book for those preparing to become district nurses, as well as those already working in district nursing services in Great Britain. The first few chapters present the development of district nursing, the local organization, the training necessary, and include a particularly good chapter on the responsibilities of the district nurse. Although techniques vary in different countries the basic principles of the techniques which are outlined are similar to those used in Canada. The chapters on family health teaching and prevention and treatment of accidents in the home present facts vital to the family's health in a concise and understandable form. Because most of the information is closely related to the activities of one organization and the suggested bibliographies are unfamiliar, its use would seem to be limited to reference purposes rather than as a text in this country.

General Psychology—Principles and Practice, by John Edward Bentley. 389 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1947. Illustrated. Price $4.00.

Reviewed by Mr. E. J. Kibblewhite, Chief Psychiatric Social Worker, Provincial Guidance Clinic, Ponoka, Alta.

This book is, as its name implies, an introductory text in general psychology. The author states of the text: "It is aimed to give a groundwork for the understanding of human life in its broadest foundations. The plan aims to be historical, psychophysiological, applied. It presupposes that the mind is a product of the body. To this end physiology is fundamental to psychology. Without it psychology could not exist. Therefore, the nurse who has had instruction and training in physiology should see the scope of psychological development with relative ease." While the writing of the text grew out of classes given to nurses the author says that the "book may be used by anyone irrespective of his field of interest, by the general student bent on seeking a psychological foundation for his knowledge of human nature."

The book is divided into four parts: the organic basis of psychology; the activity of the human senses; the means whereby learning is effected; and the problems of personality adjustment. There is also a fifth part on the "applications of psychology to nursing."

"General Psychology" is clearly written and easy to understand. The illustrative material is adequate and well chosen. The topics are not exhaustively dealt with but this would be impossible, obviously, in a book of this length which covers so much material. Before each chapter is a brief but effective summary of the material covered, and a list of suitable reference books follows. Different theories advanced by various authorities appear appropriately throughout

the book in clearly stated concise form. At the end of the book are five pages of brief identifying notes on important persons to whom reference has been made; also, a twelve-page glossary of words and phrases is a helpful, ready reference, particularly for the beginner. This is a well written book that can be recommended as an introductory text.

Lectures to Nurses — A complete series of lectures to probationary nurses in their 1st, 2nd, and 3rd years of training, by Margaret S. Riddell, A.R.R.C., S.R.N. Revised by Margaret E. Hitch, S.R.N. 460 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 9th Ed. 1948. Illustrated. Price $4.75.

Reviewed by Lucy Willis, Nursing Arts Instructor, Saskatoon City Hospital, Sask

During recent years, Canadian schools of nursing have directed considerable effort toward improving the scientific background of the nursing student. Science classes have been increased, improved, and "correlated." We endorse this policy believing that the student, later the graduate, is a better nurse for knowing "why" as well as "how." It is, therefore, surprising to discover a textbook for nurses, dated 1948, in the preface of which the author states:

"(I) have avoided as far as possible its (nursing) association with medical science excepting in the simplest form as required to give intelligent understanding." And also: " . . . this book should be a guide and help to . . . those whose interest is mainly in the exercise of their craft, and not so much in its scientific application."

This aim is achieved. The book does not deal with fundamentals but with facts. Detailed explanations are lacking. Brevity is refreshing but not desirable when it withholds important material of emphasis.

Chapter One, introducing the student to hospital routines, is practical and enjoyable reading. Subsequent chapters deal with general nursing care and "specialties." Some sections are well presented but others are incomplete. One questions the authenticity of some of the statements. No references are given. Occasionally, usually buried in the onslaught of factual material, the reader discovers a particularly vivid descriptive passage — e.g., "the inflammatory process."

The book would be an acceptable addition to a well-stocked nursing reference library, or of interest to the nursing instructor searching for new ideas, However, unfamiliar vocabulary and lack of details make it unsuitable as a textbook for students in our Canadian pattern.

Medical Manual — A handbook for interns and others associated with the work of general hospitals, by W. R. Feasby, B.A., M.D. 162 pages. Published by University of Toronto Press-Saunders. 1948. Price $2.25.

Designed as a means of acquainting senior medical students and interns with the simpler routines in the care of patients in a general hospital, this handy-sized manual would be of interest to nurses also as the condensed information is of practical value. The necessity of making proper entries in the order book is noted. Doses of drugs in common use are listed in tables, as are also the sizes of common tablets and ampoules. Certain simple nursing procedures are explained. The chapter on diet lists suitable foods for various conditions which may be under treatment — gall bladder, ulcers, low-sodium, etc.

Suggested routine procedures which would be useful as a guide to essential special investigations are included in the chapter on Clinical Methods. As the items are listed briefly, this section of the material would make useful reference for the nurse caring for the patient on whom a tentative diagnosis had been made. The requisite set-ups for trays for various examinations or treatments is concise, planned for quick reference.

Therapy Through Interview, by Stanley G. Law, M.D. 313 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1948. Price $4.95.

This book was written to guide general medical practitioners in the fairly intricate problem of sifting grain from chaff in their attempt to organize a patient's symptoms into some sort of pattern. Dr. Law, who is associated with the Minnesota Psychiatric Institute, has not written a textbook on psychiatry but brings into the simplified interviews which he has patterned many of the complicated, psychoneurotic tendencies which the patient may exhibit.

After the first three chapters which set the stage, Dr. Law records simulated interviews with several commonly-found types of patients. Chapter headings, such as "Joe has an ulcer," "Sally has heart trouble," "Donald has a fracture," illustrate the down-to-earth calibre of the interview techniques. In his foreword, the author states: "It is offered as a pattern of understanding and developing

confidence in the treatment of the many patients with borderline neurotic patterns who seek medical guidance."

The patterns of conversation, with leading questions carefully framed to uncover problem situations, are so outlined as to assist the physician to get to the root of problems that exist. Nurses do not have the responsibility of ferreting out deep-lying neuroses. Yet nurses, particularly public health nurses, very frequently encounter and interview persons in need of this very form of therapy. To these, then, we recommend a careful study of this book that they may perfect their technique of eliciting information and guiding patients.

Victorian Order of Nurses

The following changes have recently occurred on the staff of the Victorian Order of Nurses for Canada:

Appointments — Dartmouth: *Joan M. Chisholm* (Montreal Gen. Hosp.). Lachine: *Audrey Morton* (Halifax Infirmary). Montreal: *Julia L. Seed* (Royal Sussex Co. Hospital, Eng.); *Stella H. Warwick* (Homoeopathic Hospital, Montreal). Noranda-Rouyn: *Lucille Baxter* (Notre Dame Hospital, Montreal). Ottawa: *Mary T. Wurtele* (M.G.H.). Saint John, N.B.: *Leta Gordon* (Victoria Public Hospital, Fredericton). Sudbury: *Phyllis Wightman* (Victoria Hospital, London). Timmins: *Eileen Soucie* (St. Mary's Hospital, Timmins). Toronto: *Kathleen M. Olive* (Saskatoon City Hosp. and B.S.N., U. of Sask.). Vancouver: *Audrey Palvesky* (Prov. Mental Hospital, Ponoka, Alta.). Winnipeg: *Marion C. Russell* (Winnipeg Gen. Hosp.). York Township, Ont.: *Ruth J. Edward* (Toronto Gen. Hosp.); *Maureen (Robertson) Fricke* (University of Toronto School of Nursing).

Transfers — *Ruth Hammond* from Brampton to Windsor, Ont.; *Frances C. Jolliffe* from Hamilton to Napanee as nurse in charge; *Dorothy Nicol* from Hamilton to Lincoln Co., Ont.; *Muriel R. Scott* from Surrey to Vancouver; *Maureen Seymour* from Timmins to Brockville as nurse in charge.

Resignations — *Violet Camblin, Orma (Burrows) Gibson,* and *Helen Shields* from Toronto, *Kerstin Nelson* from Vancouver, *Gwendoline Watt* from Ottawa, all to take up other work; *Vivian Dodd* from Napanee and *Willa McClement* from Welland to be married;

Patricia Alcock from Edmonton, *Helen Boken* from York Township, *Helen (Nicolson) Cooper* and *Agnes (Davey) Messent* from Toronto, *Claire Hicks* from Aurora, and *Marion McEachren* from Brantford.

Nursing Sisters' Association

At the annual meeting of the *Winnipeg Unit* the following officers were elected:

President, Mrs. T. McFetridge; vice-president, E. Watt; recording and corresponding secretaries, J. Lylyk, A. Shraefel; treasurer, M. Waters. Committees: Social, H. Ross; publicity, M. Maloney; visiting, Mrs. F. A. McNeil, N. McLardy; poppy day, Mrs. W. J. McCord; memorial day, E. Hudson; advisory, M. Jerrom, E. Negus, Mmes M. Smith, D. J. Moulden.

A recent activity was a bridge when prizes were awarded by Mrs. McFetridge to the winners. Helen Ross and Sadie Horning were in charge of this event.

Manners impress as they indicate real power. A man who is sure of his point carries a broad and contented expression, which everybody reads, and you cannot rightly train one to an air and manner, except by making him the kind of man of whom that manner is the natural expression. Nature forever puts a premium on reality. What is done for effect is seen to be done for effect; what is done for love is felt to be done for love. A man inspires affection and honor because he was not lying in wait for these. A little integrity is better than any career.

—R. W. EMERSON

News Notes

ALBERTA

EDMONTON:

Royal Alexandra Hospital:

The annual banquet of the alumnae association was recently held in honor of the graduating class when sixty graduates and some two hundred members were present. The guest speaker was Dr. M. J. Huston, professor of pharmacy at the University of Alberta, whose topic was "I Remember." Dr. Huston was introduced by M. Fraser. The toast to the new class was proposed by Ida Johnson, responded to by Dorothy Turner. Telegrams of best wishes were read from the sub-alumnae in Calgary and Vancouver. Mrs. F. Aicher

was general convener for the event, assisted by Mrs. C. Douglas and V. Chapman. Membership in the alumnae was presented to the class by Mmes C. McManus and W. H. Hunt, two early graduates of the school.

BRITISH COLUMBIA

VANCOUVER ISLAND DISTRICT:

The annual meeting of Vancouver Island District, held at Nanaimo Indian Hospital, brought together members of the profession from the U.S., Britain, and Canada, including about sixty members and delegates of six chapters from Victoria to Alberni. Twenty-seven members travelled by chartered bus from the Victoria Chapter. An interesting educational film was shown by the Saanich public health nurses.

The following officers were elected: President, Sr. M. Claire; vice-president, L. Steele; secretary, Mrs. A. Quale; treasurer, R. Laird. Committee conveners: Institutional, Mrs. M. Rogers; public health, E. Fairbank; private duty, V. Aldred; *The Canadian Nurse*, Miss M. Ledoux. Councillors: Duncan, M. Fletcher; Victoria, Sr. Claire, Mrs. F. MacDonald.

CHILLIWACK:

Twenty members were present at the recent meeting of Chilliwack Chapter when Mrs. G. Roberts presided. The Purchasing Committee presented a report on the purchase of chairs for the nurses' home and Mrs. Barwell spoke concerning the Local Council of Women. Mrs. N. McGregor replaces Mrs. K. Arnold as treasurer.

The guest speaker was the Rev. A. C. Pound who told of his experiences in China, revealing some of the customs of that country. He had numerous souvenirs of his years spent there. Of special interest was a wedding slipper, three inches long, worn by a bride with bound feet.

Several members attended the provincial annual meeting held in Vancouver.

VANCOUVER:

At a recent meeting of Vancouver Chapter, the industrial nurses presented a skit — "As You Like It" — which portrayed their role in the health program. Mmes Lois Grundy and Dora Murray were the starring artistes. At a later gathering, Phyllis McLachlan, of T.C.A., took the members across Canada by colored movies and lecture.

MANITOBA

BRANDON:

C. Wedderburn was re-elected president of the Association of Graduate Nurses at a recent meeting. She will be assisted by the following officers: Vice-president, Mrs. E. Griffin; secretary, L. Booth; treasurer, Mrs. N. Dick. Committee conveners: Social, Mrs. R. Brown; scholarship, E. Cranna; visiting, M. Patterson; overseas parcels, Mrs. S. J. S. Pierce. Registrar, O. Thomas; representatives

to: Press, Mrs. M. McNee; *The Canadian Nurse*, L. Arnott.

Mrs. J. Hotson, J. Markey, and F. McCausland were delegates to the M.A.R.N. convention held in Winnipeg.

ST. BONIFACE:

The recent spring tea, held by St. Boniface Hospital Alumnae Association, was opened by G. Billyard, who is the oldest graduate of the hospital and, on behalf of the alumnae, she presented the Sisters with a pair of silver candlestick holders. Rev. Mother Provincial, Rev. Srs. Superior and Clermont received the guests, assisted by the president, Mrs. J. M. Schimnowski. Presiding at the tea table were: Mmes Harris, Forrest, Roy, Vadeboncoeur, Graf, McNulty, Peikoff, Heureux, Normandeau, and Howden. Pat Houston was the general convener for this event.

Winnipeg General Hospital:

The alumnae association has formed seven chapters in different provinces. Newsletters are sent periodically from the hospital to these groups. The chapter representatives are: Jean Boyd, Isolation Hospital, Edmonton, Alta.; Jean Houston, 3760 Lonsdale Ave., N. Vancouver, B.C.; Mrs. V. L. Annett, 633 Radcliffe Lane, Victoria, B.C.; M. Montgomery, 646 Toronto St., Winnipeg, Man.; Mrs. Bolester, 89 Burnside Drive, Toronto 10, Ont.; Miss L. J. Frohlich, 456 Pine Ave. W., Montreal 18, Que.; Mrs. D. L. McDonald, 820-14th St. E., Saskatoon, Sask.; Miss L. McAuley, 715 S. St. Andrews Place, Los Angeles 5, Calif.

The Vancouver Chapter donated $100 towards the Scholarship Fund. The Winnipeg Chapter extends greetings to all chapters and will be glad to receive news of their activities.

All graduates will be interested to know that the construction of the maternity pavilion is well advanced. The pavilion is of brick construction with concrete canopies above the windows to catch the rays of the winter sun and to keep out those of the summer sun. The building is located between Pearl and Emily streets. It faces south on to Notre Dame Ave. and is connected by underground tunnel to the power house. When first in use the 5th floor, which is the top one, will be used to provide much needed accommodation for student nurses. The 4th floor provides a fully modern delivery unit and will include an O.R. The 1st, 2nd, and 3rd floors will be used for public, semi-private, and private ward patients. Each ward will have a bathroom unit and these floors will each have a nursery.

Prenatal and postnatal care will be provided for in the ground floor accommodation where the central supply room and formulae room are also located. When first in use the pavilion will accommodate 132 beds. This will be increased to 184 when the 5th floor is taken over for patients' care.

Jean (Webster) Morrison, a 1904 graduate and one of the organizers and first presidents of the alumnae, celebrated her 80th birthday last winter. Ethel Gilroy, of the class of

1908, is now a life member of the M.A.R.N. M. Coltart is home after service as missionary in India, and is now in charge of the United Church Home for Girls in East St. Paul. Norma Atkinson is assistant matron of Kimberley Hospital, B.C. Vera Hudson, who has taken the public health course at the University of Manitoba, is with the social service department at W. G. H. Mary Earnshaw, who has obtained her B.Sc. in nursing from the University of British Columbia, is now a public health nurse at Tisdale, Sask.

At the recent banquet, in conjunction with the M.A.R.N. annual meeting, Mrs. W. J. Harrington, of Neepawa, was presented with an honorary membership in the association by Irene Barton, retiring president. This honor was bestowed on her in recognition of her many years' service to this group and to nursing in the province. Mrs. Harrington, a 1907 graduate, nursed in Fernie, B.C., before returning to Winnipeg. After practising private duty for a time, she went to Dauphin where she was superintendent of nurses for five years. Returning to her alma mater, she served as assistant superintendent for a few years. From 1915 to 1916 Mrs. Harrington was secretary of the M.A.R.N.

NEW BRUNSWICK

EDMUNDSTON:

Nineteen members were present at a recent meeting of Edmundston Chapter when the Nominating Committee presented the following slate of officers: Honorary president, Mrs. M. V. Madore; president, Mrs. Albina Titus; vice-presidents, Sr. St. Charles, Annette Sormany; secretary, Grace Stevens; treasurer, Corrine Pichette.

FREDERICTON:

Victoria Public Hospital:

One hundred and ten nurses were present at the reunion dinner held by the alumnae association at Pythian Castle. In the receiving line were Mmes C. W. Anderson, B. Colter, and R. Perley. The guests for the dinner included: H. Schurman, superintendent of nurses, as honorary president; the 1949 graduating class of twenty-seven nurses; and Dr. G. E. Chalmers as special speaker. He gave an interesting talk on "Cancer and Its Treatment," stating that both the general public and doctors must become more cancer-conscious.

An enjoyable dinner was served by the Pythian Sisters and music was rendered by Mrs. A. Barker. M. Warman proposed the toast to the king; Mrs. A. Webb to the alma mater, responded to by A. Charters; A. Miller to the doctors, responded to by Dr. Chalmers; I. MacDonald to the graduating class, responded to by E. Hatto.

Mrs. Anderson presided at the business meeting when the following officers were elected: Honorary president, H. Schurman; president, Mrs. R. Perley; vice-presidents,

Mrs. W. Tenhaff, V. Good, Mrs. F. Osborne; secretary-treasurer and assistant, M. Brewer, K. MacFarlane; additional executive, M. Barry, Mrs. B. Colter.

Mrs. F. Howard and Mrs. G. De Long, of Fort Fairfield, Me., Ida Brewer, of Vancouver, and Mrs. S. Polden, of London, Eng., V.P.H. graduates, who have not attended the reunion dinner for a number of years, were welcomed by the president.

MONCTON:

At a meeting of Moncton Chapter a collection was taken for the monthly box to be sent to the Rest-Break Homes in England. The members were entertained by three films — "Newfoundland," "Dress Designing," and "What's On Your Mind."

The chapter recently presented a sterling silver dish to the retiring president, Phyllis Noble. The staff nurses of the hospital also made a presentation of necklaces and earrings to Misses Noble and Roach. From the private duty nurses they received leather cases, fitted with beauty preparations. Miss Noble has been floor supervisor for a number of years, with Miss Roach her assistant. They have left for the New England Deaconess Hospital where they will take similar positions.

SAINT JOHN:

Dr. Helen Hale was guest speaker at recent meeting of Saint John Chapter when B. Seaman, the president, was in the chair. The General Nursing Section reported that plans were complete for the annual dance and bridge. Lunch was served in the nurses' dining-room of the Provincial Hospital, scene of the meeting, with Mrs. Lewin, superintendent, as hostess.

General Hospital:

Thirty members were present at a recent meeting of the alumnae association when K. Bell, vice-president, was in the chair. Lois Floyd was appointed to represent the alumnae at the N.B.A.R.N. annual meeting to be held in September, with C. MacLeod as alternate. Arrangements were completed for the annual dinner and dance for the 1949 graduates. A "bring and buy" sale, with Miss Bell as auctioneer, was enjoyed and a substantial sum was realized.

The guest speaker was Councillor Edna Steele who, in her humorous way, told of the events of one week in the life of a city councillor. Refreshments were served under the direction of Mrs. M. O'Neal.

The nurses' residence was the scene of a dance held by the student nurses when arrangements for this event and the decorations were looked after by the intermediates. The guests were welcomed by Orma Smith, director of nurses, and her assistant, Louise Peters.

Lillian (Wilson) Saunders was entertained with showers and teas prior to her marriage. For the past nine years Mrs. Saunders has been night supervisor. Georgie Murchison replaces her. Pat Carson is now doing private duty.

Provincial Hospital:

Recent additions to the staff include: Doris Ward, Joyce Elliott, Ingra Jensen, Beatrice Lord, Verna Belyea, Mrs. Ruby Myles. Marion (Dykes) Smith is now residing in Scotland.

St. Joseph's Hospital:

Marie Wallace, the president, presided at a recent meeting of the alumnae.

ONTARIO

District 7

KINGSTON:

Forty-two members and guests were present at District 7 annual meeting when the chairman, Helen Corbett, presided. It was voted that Vera Preston, secretary-treasurer of the district, represent the group at the R.N.A.O. annual convention. The convener of the Selection Committee reported that the bursary given by the district had been awarded and the candidate will enter the Kingston General Hospital School of Nursing in September. Reports from the General Nursing Section revealed the benefit derived from refresher courses held in Kingston and Brockville. The local chapters have had a busy season and food parcels are being sent to many Scottish nurses. The Nominations Committee report was presented by Mrs. E. Stangeby and read by G. Purcell.

The guest speaker, introduced by Miss Sharpe, was Mrs. Spooner, who had spent some time in China before going to India. Her interesting travelogue on China and Japan was enjoyed by all present. Miss Corbett extended the members' appreciation to Mrs. Spooner. A delightful hot supper was served by Miss Acton and her staff at the General Hospital

Ontario Hospital:

At the annual meeting of the alumnae association, the following officers were elected: Honorary president, Mrs. D. O. Lynch; president, Mrs. N. Ferguson; vice-presidents, Mmes M. White, A. Kennedy; secretary, Mrs. G. Pomeroy; treasurer, Mrs. E. Peters. Committee conveners: Social, Mmes M. Orr, M. Lumb; visiting, Mrs. R. Burke. Councillors: Mmes D. Love, H. Graham, T. McDonald, F. Fairman, G. Greenwood, W. Newman. Representatives to: *The Canadian Nurse*, Mrs. Greenwood; Film Council, E. G. Smith, superintendent of nurses, and Mrs. M. Webster. Mrs. Fairman was re-elected editor of the *News Bulletin*.

A future project will be to assist a graduate nurse of the hospital who was blinded as the result of a motor accident.

A recent alumnae meeting took the form of a pot-luck supper when thirty members were present. Mrs. Ferguson was in charge of the business meeting and reports were given by the secretary and treasurer. Plans were made for a benefit bridge and euchre, the conveners being Mmes Lumb and White.

At a later meeting, Dr. G. E. Wilson, assistant superintendent of the hospital, presented a film entitled "The Feeling of Rejection." Mrs. Webster introduced Dr. Wilson to a large number of student nurses, affiliate students, and alumnae members. The speaker gave pertinent information concerning the frequency of mental upsets in children now attending school and of the need for more money to promote proper treatment of mental illness. He stated it was up to the nurses to go out to "preach the gospel" concerning this need. The film is the story of a 23-year-old girl who was finally referred to a psychiatrist after exhaustive physical examination revealed no cause for frequent headaches and fatigue.

Mrs. Orr and her committee served lunch to all present.

M. Pollitt, of Toronto, recently spent a week of observation at the hospital regarding the affiliation courses for nurses.

District 10

PORT ARTHUR:

A regular meeting of District 10 was held at St. Joseph's General Hospital recently, the chairman, Violet Weston, presiding. It was decided to participate in a plan to provide funds for travel assistance to enable nurses from war-torn countries to attend the I.C.N. conference in Sweden.

The members were honored to have Madalene Baker, registry adviser, R.N.A.O., from London as guest speaker. Speaking on nursing education and service, she stated that nursing today is a professional challenge and a public responsibility. The nursing profession was alert to the need for a change in both nursing education and nursing service, and was earnestly endeavoring to do something about it.

Demonstrations were being conducted which in total review would point the way in

which the health needs of the people could be best met. The V.O.N. was demonstrating a strictly rural bedside service in Lincoln County, Miss Baker said. The field of private practice was keeping pace with the times. Last year nine registries offered shared nursing care.

An informal discussion was held at the conclusion of the talk. The speaker was thanked by Miss Weston.

QUEBEC

District 11

Le Comité du District 11, chapitre français, A.N.P.Q., a le plaisir d'annoncer qu'une Bourse d'Etude de $500 est offerte aux membres du District 11 qui désireraient poursuivre des études soit en Hygiène Publique soit en Sciences Hospitalières.

Les formules de demande peuvent être obtenues de la secrétaire — *Mlle Berthe Bourbonnais, 4642 rue St-Denis, Montréal 34.* Ces formules devront être complétées et retournées avant le *1er juillet.*

Montreal:

Royal Victoria Hospital:

Ethel Johns, LL.D., R.N., was the guest speaker at the graduation dinner given by the alumnae association in honor of the 1949 class. Her address, entitled "Victorian Silhouettes," described the work of outstanding nurses of the Victorian era — Mrs. Isabel Hampton Robb, Adelaide Nutting, and Lavinia Dock. The toast to the new class was proposed by F. Gass and responded to by B. A. Smith. Fanny Munroe, director of nurses, announced the prize winners as follows: Mabel F. Hersey prize, awarded to student in A section who receives highest marks in examinations, Vivien Forsyth, Drumheller, Alta.; Nellie Goodhue prize, awarded to student in B section who receives highest marks, Sadie Hall, Sheet Harbour, N.S.; bedside nursing, Marion Mersereau, McAdam, N.B.

The guest speaker at a recent well-attended alumnae meeting was Dr. John MacLean, assisted by J. Peterson, who gave an educational demonstration and lecture on the "artificial kidney."

Frances Bell is industrial nurse for the Consolidated Mining and Smelting Co. of Canada Ltd., Trail, B.C. After taking public health at the University of Toronto, she served with the V.O.N. N. Bilecki is now on the O.R. staff of the Children's Hospital, Winnipeg. Ann Putnam and Ann Thompson are at St. Mary's Hospital, Paddington, London, Eng. Valda Howard is engaged in district nursing with the V.O.N., Chatham, Ont. Jean (Rowat) Gorrell was a recent visitor to the hospital.

Quebec City:

Jeffery Hale's Hospital:

At a recent meeting of the alumnae association, educational films were shown on nursing. The proceeds of the successful bridge will go towards the general funds of the association.

Doreen Rourke and Patience Ellis are on the general duty staff at the Children's Memorial Hospital, Montreal.

Sherbrooke:

At recent meetings of Sherbrooke Hospital Alumnae Association, it was agreed to continue sending food parcels to aged British nurses. The Red Cross was given a donation of $25. The recent raffle proved most successful. Plans were made for the graduation dinner and dance. A brush demonstration was held at one meeting when a percentage of sales went to the association funds.

Following the March alumnae gathering, the English Chapter of District 3 met when Miss Malone and Mrs. Shepherd were appointed delegates to the A.N.P.Q. convention in Montreal. The guest speaker was Dr. Quintin whose lecture on "Recent Developments in Modern Therapeutics" proved instructive.

A. Hyndman has resigned as industrial nurse from the Canadian Ingersoll-Rand Co. Ltd. to be married. She is replaced by O. Symons. Heather Matthews is taking a psychiatric course in London, Ont.

The first "sod-turning" recently took place for the new hospital. The nurses' home is also under construction.

SASKATCHEWAN

Moose Jaw:

A special meeting of Chapter 6 was held recently at the Regional Health Centre when E. Robertson, national supervisor of the V.O.N. for the western provinces, was the speaker. A motion was moved and unanimously approved to support the establishment of a V.O.N. branch in Moose Jaw. At a public meeting held later the city decided to support this project. At a regular meeting of the chapter, Mrs. O. Backlin held the winning ticket in the annual draw for a suit.

General Hospital:

The annual Shamrock Ball, under the sponsorship of the alumnaes of the General and Providence Hospitals, was attended by over four hundred guests.

The following nurses have resigned from the staff: Ruth Roney, F. Whelan, Mmes D. Bennett, A. Hubert; E. Caldwell to go to Nipawin; J. Brown to join C.P.R. clinic staff. Mmes A. Trower and A. Kennedy are doing general duty at the hospital.

Regional Health Centre:

Joyce Arrowsmith is a new addition to the staff.

NORTH BATTLEFORD:

Sr. Patrick was presented with a gift of money at a recent meeting of North Battleford Chapter on her departure for a holiday in Ireland.

Notre Dame Hospital:

A. Chuback and S. Simonson are welcomed to the staff. Margaret Bonderoff is leaving to take a post-graduate course in obstetrics at Royal Victoria Hospital, Montreal.

PRINCE ALBERT:

At a recent meeting of Prince Albert Chapter plans were made for a party at the San for the two graduating classes. It was voted to send $10 to the Swedish Nurses' Association towards helping other nurses to attend the I.C.N. meetings. A "Bon Voyage" is extended to Agnes Campbell and Estelle Wood who will be attending this conference. It was reported that the chapter has been active in the work of the Red Cross milk bank. The guest speaker was Dr. Hyjertaas who told the members of his trip to the British Isles and Norway.

REGINA:

General Hospital:

Edna Guse, supervisor, E.E.N.T., has resigned and is succeeded by S. McCurrach.

Grey Nuns' Hospital:

Rev. Sr. H. Martel, director of nursing service, has been transferred to Montreal. Mrs. T. McIsaac, head nurse, E.E.N.T.ward, has resigned. She is replaced by Helen Johnson. Y. Nishimura has returned to take the position of pediatric supervisor.

Public Health Department:

Marion McEachern, formerly with the V.O.N. in Brantford, Ont., is now on the city public health staff. Another new addition is Mrs. M. Thompson, formerly with the Children's Aid. Mrs. Paul Sherrick has resigned from the staff.

SASKATOON:

City Hospital:

A social evening followed a recent meeting of the alumnae association when members of the 1951 class put on an amusing one-act play entitled "Ain't Love Grand!" C. Casswell has joined the O.R. staff. Irene MacInnes is another newcomer. B. Fleming, neurological ward supervisor, has resigned to be married.

St. Paul's Hospital:

The building of the new laboratory was recently started. This will provide an extension of forty-five beds.

Two of St. Paul's students had the honor of presenting the good wishes of the Sisters and students to Mrs. Louis St. Laurent on the occasion of the visit of the Prime Minister and Mrs. St. Laurent to Saskatoon. A delightful entertainment was given by Freshmen B Class to mark the advent of Easter. On this occasion, the School Glee Club introduced the new School Song.

G. Evans, from Russell, Man., was a visitor to the school.

Saskatoon Sanatorium:

Vera Buchanan is a new member of the staff. Cecile Casswell has resigned as O.R. nurse, while Ellen Epp is a new addition to that staff. Llewyn Saunders is now with the City Health Department.

YORKTON:

Following a regular meeting of Yorkton Chapter, the members of the graduating class of the General Hospital were entertained.

Positions Vacant

• CANADIAN RED CROSS SOCIETY •

invites applications for Administrative and Staff positions in Hospital and Public Health Nursing Services for various parts of Canada.

The majority of opportunities are in Outpost Services in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia. Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.

Matron immediately for 18-bed hospital. Salary: $135 per mo. with full maintenance. **Graduate Nurses (2).** Salary: $110 per mo. with full maintenance. 8-hr. day, 6-day wk. Apply, stating qualifications, Sec.-Treas., Little Bow Municipal Hospital No. 25, Carmangay, Alta.

Graduate Registered Nurse Instructor for Training School of 75 students in 150-bed General Hospital. Gross salary commencing at $190 per mo. increasing to $220 per mo. 8-hr. day, 6-day wk. 1 mo. vacation annually. Apply, stating qualifications, post-graduate experience, age & religion, Administrator, General Hospital, Chatham, Ont.

Nursing Arts Instructor—Gross salary: $195. **Science Instructor**—Gross salary: $205 less $30 maintenance per mo. **Clinical Supervisor**—Gross salary: $180 less $30 maintenance per mo. 188-bed hospital. 44-hr. wk. Apply, stating qualifications & experience, Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Surgical Instructor for School of 200 students. Minimum mo. salary: $180, with annual increment & recognition for post-graduate experience. 44-hr. wk. **Night Supervisor & Assistant**—alternating 3:30-12 & 11:30-8 duty. Minimum salary: $175 with increases as above. 44-hr. wk. For further details & application apply c/o Box 6, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Supervisor for Psychiatric Pavilion of 37-beds at General Hospital, Winnipeg, Man., for July 1. Beginning salary: $137-152 plus maintenance, depending on experience & preparation. Apply Supt. of Nurses.

Asst. Night Supervisor for 400-bed hospital. Apply Director of Nurses, General Hospital, Saint John, N.B.

Public Health Nurses for Victorian Order of Nurses, Toronto Branch. Minimum salary: $2,087. 1 mo. vacation after 1 yr. service. Allowance for sick leave. Pension. Initial uniform allowance. Apply Miss E. Cryderman, District Supt., V.O.N., 281 Sherbourne St., Toronto 2, Ont.

Public Health Nurses for Bruce County Health Unit. Salary: $1,900-2,500 according to experience. Car provided or car allowance of 8 cts. Apply Dr. William Fowler, Walkerton, Ont.

Vancouver General Hospital requires **General Staff Nurses** for *vacation relief & permanent staff*. Salary: $172 gross, including current Cost of Living Bonus. Extra premium for evening or night duty. Registration in British Columbia required. For further information apply Director of Nursing, General Hospital, Vancouver, B.C.

Staff Nurses, eligible for registration in Michigan, U.S.A., for all services in modern 200-bed hospital. Salary: $216 per mo. for 44-hr. wk. 6 mo. increase. $10 extra for 3-11 & 11-7 duty. 7 legal holidays. 12 vacation days & 10 days sick leave per yr. Cafeteria meal service. Laundry furnished. Apply Supt. of Nurses, General Hospital, 461 W. Huron St., Pontiac 18, Mich.

General Duty Nurses for 150-bed Sanatorium. 8-hr. broken day, 6-day wk. 4 wks. holiday after 1 yr. service. For further information apply Supt. of Nurses, Niagara Peninsula Sanatorium, St. Catharines, Ont.

Registered Nurses for General Staff Duty in 45-bed hospital. Salary: $110 plus full maintenance. 8-hr. day, 6-day wk. 3 wks. holiday after 1 yr. service plus statutory holidays. 1 wk. sick time with pay. Apply Supt., County of Bruce General Hospital, Walkerton, Ont.

General Duty Nurses. Beginning salary: $150 per mo.; after 6 mos.: $155; 1-2 yrs.: $160; after 2 yrs.: $165 plus full maintenance. Straight 8-hr. shifts. 6-day wk. After 1 yr. service, 1 mo. holiday with pay. Nurses' residence adjoining hospital. Apply Matron, Municipal Hospital, Vulcan, Alta.

Graduate Nurses for Staff Positions with Victorian Order of Nurses, Toronto Branch. Minimum salary: $1,800. 1 mo. vacation with pay after 1 yr. service. Allowance for sick leave. Pension. Initial uniform allowance. Apply Miss E. Cryderman, District Supt., V.O.N., 281 Sherbourne St., Toronto 2, Ont.

Graduate Nurses (3) immediately. Apply, with credentials & reference, to Doctors Hospital Inc., 6481 Côte des Neiges Rd., Montreal 26, Que. (*Phone:* AT 1171).

Supt. of Nurses for Fall Term for 140-bed General Hospital with Training School of 50 students. Apply, stating qualifications, experience, salary expected, Supt., Aberdeen Hospital, New Glasgow, N.S.

Matron for 15-bed hospital. Salary: $160 plus maintenance. For further particulars apply Sec.-Treas., Municipal Hospital, Myrnam, Alta.

Nursing Arts Instructor & Science Instructor to join Teaching Staff of 450-bed hospital. No. of students, 150. Positions open now. Apply, stating qualifications, Principal, School of Nursing, General Hospital, Saint John, N.B.

Operating-Room Supervisor & Nursing Arts Instructor. Immediate opening. Good location. State Capitol with many civic advantages. Salary open. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

Floor Supervisor & Registered Nurses for General Duty immediately. 8-hr. duty, 6-day wk. Apply Acting Supt. of Nurses, General Hospital, Woodstock, Ont.

Public Health Nurses for generalized Public Health work in County Health Unit. Halfway between Ottawa & Montreal. Salary: $1,900 to start. Cars provided. Must be bilingual (French & English). Apply, stating age, experience, etc., Director, Prescott & Russell Health Unit, 33 Main St. W., Hawkesbury, Ont.

General Staff Nurses, 44-hr. wk. Starting gross salary: $155. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

Registered Nurses for General Staff in 20-bed hospital. Salary: $142.50 per mo. plus laundry & $15 bonus payable every 3 mos. 8-hr. day. Cumulative sick leave allowance, hospitalization plan. Permanent hospital under construction. Apply Supt., Oakville & District Temporary Hospital, Oakville, Ont.

Registered Nurses for General Duty. Salary: $120 per mo. plus full maintenance. Apply Director of Nursing, County General Hospital, Welland, Ont.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan, 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

Graduate Floor Duty Nurses. Salary: $120-$130 per mo. plus full maintenance. 8-hr. day, 6-day wk. Free hospitalization & medical & nursing care if ill, & laundry. Vacation with pay at end of 1 yr. service. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.

General Duty Nurses for 350-bed Tuberculosis Hospital. Blue Cross hospitalization plan. For further information apply Miss C. L. Bartsch, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Nursery Supervisor (experienced) for small Nursery Unit. Post-graduate course in Obstetrics & ability to teach students essential. Apply Director of Nursing, Civic Hospital, Peterborough, Ont.

Public Health Nurses for Northumberland-Durham Health Unit. Salary range: $1,800-2,500. Allowance for public health or other nursing experience in starting salary. Car provided or car allowance. Apply Dr. C. W. MacCharles, M.O.H., Cobourg, Ont.

Registered Nurses for General Staff Duty—(Div. of T. B. Control, British Columbia): **Vancouver Unit**—Salary: $168 per mo. with increments over 5-yr. period (including current C.L.B.). No residence accommodation. **Tranquille Unit**—Salary: $174 per mo. with increments over 5-yr. period (including current C.L.B.). Attractive modern residence. Recreational facilities. Exhilarating climate. 8-hr. day, 5½-day wk. (Overtime paid when necessary.) Annual vacation, 1 mo. with pay & 11 statutory holidays. Sick leave, 14 days per yr. (cumulative) plus 6 days for incidental illness. Superannuation plan. Further information & applications may be obtained from Supt. of Nurses in respective Units or Director, T. B. Nursing, Vancouver, B.C.

Registered Nurses (3) for new 12-bed hospital. Salary: $130 per mo. with everything found. Apply H. E. Corbett, Benito, Man.

Graduate Nurses for: **Operating-Room & Floor Supervisors. General Duty.** Sanatorium-General Hospital. Salary: $125 per mo. plus single room, meals, laundry. 3 wks. vacation per yr. Half travelling expenses coming. Increase according to qualifications. Apply Director of Nurses, Misericordia Hospital, Haileybury, Ont.

General Duty Nurses for modern 90-bed hospital in Interior of B.C. Pop. approx. 6,000. All entertainment facilities in pleasant climate. 2½ hrs. by air from Vancouver. Straight 8-hr. day. Current. R.N.A.B.C. schedule in effect. Fare up to $60 refunded after 6 mos. Attractive residence. Apply Miss E. Jones, Acting Supt. of Nurses, Prince George & District Hospital, Prince George, B.C.

General Duty Nurses for Day and Night Duty in small hospital. Good salary. Apply Supt., Rosamond Memorial Hospital, Almonte, Ont.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $160 per mo. less $25 for board, residence, laundry. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Matron, General Hospital, Prince Rupert, B.C.

Graduate Nurses for General Duty in Operating-Room, Obstetrical Dept., Medical & Surgical Floors. Modern well-equipped 100-bed hospital. Minimum gross salary: $155 per mo. Apply St. Mary's Hospital, Camrose, Alta.

Obstetrical Supervisor for 50-bed Maternity Hospital. Apply, stating qualifications, salary, etc., Supt., Catherine Booth Hospital, 4400 Walkley Ave., Montreal 28, Que.

Supt. & Graduate Nurses for new 52-bed hospital. Apply, stating qualifications, experience & salary expected, Sec., Pontiac Community Hospital, Shawville, Que.

General Duty Nurses (2) for Community Hospital in Peace River District. Salary: $130 per mo. plus full maintenance. Wire collect to M. F. Malkinson, Fairview, Alta.

General Night Supt. for 135-bed hospital. 11-7, 6-day wk. Apply General Hospital, Stratford, Ont.

Public Health Nurses (2) (qualified) for Generalized Service. Apply in writing, stating qualifications, age, experience, salary expected, etc., Medical Officer of Health, Health Dept., City of Kingston, Ont.

Supt. of Nurses for Yarmouth Training School (70 beds) by July 1 (urgent). Full maintenance. State qualifications, experience, salary expected. Also **Instructor of Nurses** by Aug. 15. Apply Mr. A. G. MacLellan, Beacon St., Yarmouth, N.S.

Instructor (qualified) by Sept. 1. Apply Supt., City Hospital, Sydney, N.S.

Science Instructor by Sept. 1. Minimum salary: $2,000 yearly. Apply, stating qualifications & experience, Supt. of Nurses, Hospital for Sick Children, Toronto 2, Ont.

District Nurses in Province of Alberta. Rural service. Emergency treatment, preventive & maternity program. Furnished cottage, fuel, water supplied. Salary schedule: $1,920-2,400. Sick leave, annual vacation, pension. Present Cost of Living Bonus $19.50 per mo. Apply Acting Director, Nursing Division, Dept. of Public Health, Edmonton, Alta.

NURSING INSTRUCTRESSES

Salary $185 to $225 per month
(Including Cost-of-Living Bonus)

required for

Province of Sask., Dept. of Public Health, for duty in provincial mental institutions. Initial salary depending upon qualifications and experience.

Requirements: ability to prepare and present lectures, to demonstrate and explain nursing techniques, to supervise nurses in training and keep simple records; considerable experience in psychiatric nursing, preferably including or supplemented by experience in nursing instruction; Grade XII and graduation from an approved school of nursing.

For applications and further information apply to:

Public Service Commission, 1730 Scarth St. Regina, Sask.

PRINCIPAL PSYCHIATRIC NURSE

Salary $170 to $205 per month
(Including Cost-of-Living Bonus)

required for

Province of Sask., Dept. of Public Health, Psychopathic Ward, Regina General Hospital. An experienced nurse with psychiatric training for administrative duties relating to the management of nursing staff and patient care services; to supervise staff on male wards; to assist in the instruction and orientation of newly allocated personnel including undergraduate nursing affiliates, etc.; to supervise and train the orderly staff.

For applications and information apply to:

Public Service Commission, 1730 Scarth St., Regina, Sask.

PUBLIC HEALTH NURSES

Salary $165 to $200 per month
(Including Cost-of-Living Bonus)

required for

Province of Sask., Dept. of Public Health. Staff nurses for a generalized public health nursing program in Regina and districts in Saskatchewan. Minimum salary: $145 per month plus Cost-of-Living Bonus plus expenses while away from headquarters. Minimum salary for nurses holding diploma in public health nursing: $152 per month plus Cost-of-Living Bonus. Annual increment $84 per annum.

For applications and further information apply to:

Public Service Commission, 1730 Scarth St., Regina, Sask.

REGISTERED NURSES

Salary $155 to $210 per month
(Including Cost-of-Living Bonus)

required for

Province of Sask., Dept. of Public Health, for duty in provincial mental institutions at North Battleford and Weyburn and also for the Psychopathic Ward, Regina General Hospital. Graduates of an approved school of nursing for general duty nursing.

For applications and information apply to:

Public Service Commission, 1730 Scarth St., Regina, Sask.

Official Directory

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

Pres., Miss B. Emerson, 23 Rene LeMarchand Mns., Edmonton; Vice-Pres., Misses J. S. Clark, F. J. Ferguson; *Councillor*, Rev. Sr. Annunciata, Banff; *Committee Chairmen: Institutional*, Miss A. Anderson, Royal Alexandra Hosp., Edmonton; *Private Duty* (acting), Mrs. J. H. Cashore, Lethbridge; *Public Health*, Miss G. D. Hutchings, Strathmore; **Registrar, Mrs. C. Van Dusen, Reynolds Bldg., 10026-102nd St., Edmonton.**

Ponoka District, No. 2, A.A.R.N.

Pres., Miss Eleanor Stark; Vice-Pres., Miss Vera King; Sec.-Treas., Miss Valerie Wheeler, Prov. Mental Hospital, Ponoka; *Reps.* to: *Labor Relations*, Miss Florence Morrison; *Nurse Placement*, Miss Margaret McNinch; *The Canadian Nurse*, Miss Margaret Davies.

Calgary District, No. 3, A.A.R.N.

Chairman, Miss G. Hutchings, Strathmore; Vice-Chairman, Miss V. Molesky; Sec., Miss M. Urch, 450 Scarboro Ave.; Treas., Miss M. Watt, Health Dept.; *Committee Chairmen: Institutional*, Miss J. Porteous; *Public Health*, Rev. Sr. M. Laramee; *Private Duty*, Miss J. Brown; Registrar, Comm. Nursing Bureau, Miss E. Wainwright, 1724-14th Ave. W.

Medicine Hat District, No. 4, A.A.R.N.

Pres., Miss M. Middleton, 177-3rd St.; Sec., Mrs. K. Baumback, 237 Aberdeen St.; Treas., Mrs. L. Garratt, 33-12th St.; *Executive*, Mrs. D. Fawcett, 403-4th St.; Miss E. Breakell, Nurses' Home; *Rep.* to *The Canadian Nurse*, Mrs. C. Keating, 4-5th St.

Red Deer District, No. 6, A.A.R.N.

Pres., Miss K. Macalister; Vice-Pres., Miss M. Murray, Mrs. O. Johanson; Sec.-Treas., Miss Lilla Wright, Box 180; *Committee Conveners: Visiting*, Miss Torrance; *Social*, Mmes Galbraith, Humber; *Rep.* to *The Canadian Nurse*, Miss O. McIlvride.

Edmonton District, No. 7, A.A.R.N.

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Lethbridge District, No. 8, A.A.R.N.

Pres., Miss A. Short; Vice-Pres., Sr. M. Peters, Miss B. Hoyt; Sec., Miss L. Watson, 605-11th St. S.; Treas., Miss I. Schmaltz; *Committee Conveners: Program*, Miss M. Mills; *Social*, Miss A. Hofer; *Rep.* to *Press & The Canadian Nurse*, Miss D. Watson.

BRITISH COLUMBIA

Registered Nurses' Association of British Columbia

Pres., Sr. Columkille; Vice-Pres., Misses E. Paulson, J. Jamieson; Hon. Sec., Miss A. Creasor; Hon. Treas., Miss E. Gilmour; Past Pres., Miss E. Mallory; *Committee Chairmen: Public Health Nursing*, Miss M. Macdonell; *Private Duty Nursing*, Miss K. MacKenzie; *Institutional Nursing*, Miss M. Richmond; Dir., Placement Service, Miss E. Braund, 1101 Vancouver Block, Vancouver; **Executive Secretary & Registrar, Miss Alice L. Wright, 1101 Vancouver Block, Vancouver.**

New Westminster Chapter, R.N.A.B.C.

Pres., Miss Muriel Hamilton; Vice-Pres., Mrs. M. Gartside; Rec. Sec., Miss Marion Ward, Memorial Hospital, Langley Prairie; Corr. Sec., Mrs. Corrigan; Treas., Miss Ruth Peterson; *Rep.* to *The Canadian Nurse*, Miss N. Bankier.

Vancouver Island District

Pres., Sr. M. Claire; Vice-Pres., Miss L. Steele; Sec., Mrs. A. Quale, 3030 Carnarvon, Victoria; Treas., Miss R. Laird; *Committee Conveners: Institutional*, Mrs. M. Rogers; *Public Health*, Miss E. Fairbank; *Private Duty*, Miss V. Aldred; *Rep.* to *The Canadian Nurse*, Miss M. Ledoux; *Councillors: Duncan*, Miss M. Fletcher; *Victoria*, Sr. M. Claire, Mrs. F. MacDonald.

Victoria Chapter, R.N.A.B.C.

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East Kootenay District

Fernie Chapter, R.N.A.B.C.

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West Kootenay District

Trail Chapter, R.N.A.B.C.

Pres., Mrs. R. Farmer; Vice-Pres., Miss E. Hughes, Mrs. J. Munch; Rec. Sec. & Treas., Miss M. Velde; Corr. Sec., Miss C. Campbell, Nurses' Res.; *Rep.* to *The Canadian Nurse*, Mrs. J. Thornber, 1090 Pine Ave.

Okanagan District

Kamloops-Tranquille Chapter, R.N.A.B.C.

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Greater Vancouver District

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Vancouver Chapter, R.N.A.B.C.

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Manitoba Association of Registered Nurses

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NEW BRUNSWICK

New Brunswick Association of Registered Nurses

Pres., Miss Hilda M. Bartsch, T.B. Hospital, Moncton; Past Pres., Miss M. Myers; Vice-Pres., Misses M. E. Hunter, M. Downing; Hon. Sec., Sr. St. Charles; *Standing Committee Conveners: Institutional Nursing*, Sr. M. Rosarie, St. Joseph's Hospital, Saint John; *Private Duty Nursing*, Mrs. B. Nash Smith, 63 Bonaccord St., Moncton; *Public Health Nursing*, Miss M. Clark, 285 Germain St., Saint John; *Legislation*, Miss M. I. Lane, R.R. 4, Fredericton; *The Canadian Nurse*, Miss K. E. Bell, Saint John General Hospital; *Councillors*, Misses B. A. Beattie, M. E. Ingham, M. McMullen, M. Dunbar, M. V. Anderson, B. M. Hadrill; **Executive Secretary, Miss Alma F. Law, 29 Wellington Row, Saint John.**

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ONTARIO

Registered Nurses Association of Ontario

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

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